TRAINING AND ASSESSING TRAUMA-FOCUSED COUNSELOR COMPETENCY: A MULTI-CASE PILOT STUDY

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Abstract

Child maltreatment has devastating effects that can be minimized with trauma-focused evidence-based treatment (TF-EBT). Many children who experience maltreatment are unable to gain access to the appropriate services due to client traits, limited resources, counselor traits, and education of counselors. The focus of this paper is on counselor education related to providing TF-EBTs. The results of a needs assessment on the courses and knowledge masters level psychology students obtain related to treatment of child victims of maltreatment clarified that most graduate psychology students do not take child therapy or trauma courses. Also, students demonstrated limited knowledge of TF-EBTs. The results of a literature review on training counselors in TF-EBTs were then used to inform a training program for graduate students in psychology. A multi-case pilot study was conducted to explore the impact of the intern-training program to improve counselor competency to treat victims of child maltreatment and to pilot a trauma-focused counselor competency assessment measure. Trainee and supervisor feedback was very positive for both the training programs and the assessment measure. Results from the assessment measure showed that trainees demonstrated significant improvement in their competencies from pre to mid assessment. The scores then decreased slightly at the final assessment. Implications and possible reasons for the results are examined.

Keywords: counseling, child maltreatment, abuse, neglect, trauma, treatment, training, competency, competency assessment.

Contents

LIST OF TABLES

LIST OF FIGURES

Executive Statement

In 2015, Child Protective Services received approximately 4 million referrals, which included 7.2 million children, for concerns of child abuse or neglect (USDHHS, 2017). The negative consequences of maltreatment reach across all aspects of victims' lives including mental, medical, financial, legal, educational, and social functioning (Fang, Brown, Florence, & Mercy, 2012). There are cost-effective treatments that have been shown to reduce trauma-related symptoms; however, most counselors are not using these evidence-based treatments (EBTs) (Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013; Gospodarevskaya & Segal, 2012). Therefore, many victims of child maltreatment are not receiving the quality mental health treatment than can help them heal.

There are a variety of factors that are related to the treatment that victims receive, including client traits (Cohen & Mannarino, 2000; Lohman, Pittman, Coley, & Chase-Lansdale, 2004), limited resources (Borntrager et al., 2013), counselor traits (Allen, Gharagozloo, & Johnson, 2012; Driscoll et al., 2003), and counselor education (Allen, Wilson, & Armstrong, 2014; Nelson & Graves, 2011). How well a child can benefit from mental health treatment may, in part, depend on their own traits, such as socioeconomic status, age, intellectual functioning, family dynamics, engagement in the therapeutic process, and race/culture (Cohen & Mannarino, 2000; Hanson et al., 2013; Lohman, Pittman, Coley, & Chase-Lansdale, 2004; Widom, Czaja, Wilson, Allwood, & Chauhan, 2012). While child maltreatment is widely considered a costly problem, evidence-based treatments to help victims heal and minimize the negative impact of maltreatment are limited and most counselors do not use them (Borntrager et al., 2013; Conrad, 2006).

Counselors' beliefs about how therapy should be structured and theoretical orientation may impact their willingness to use TF-EBTs, but training can reduce counselors' resistance to TF-EBTs (Borntrager et al., 2013). Even with training, using traditional training methods, counselors still fail to implement TF-EBTs with high fidelity (Allen & Johnson, 2012; Allen et al., 2014).

As counselors are unable to change client traits, solutions should target the counselors themselves. Researchers argue that a lack of training on TF-EBTs is a key factor in the limited supply of effective intervention for victims of maltreatment (Allen & Johnson, 2012; Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013; Driscoll et al., 2003; Hanson et al., 2013; Kolko, Cohen, Mannarino, Baumann, & Knudsen, 2009; Nyman, Nafziger, & Smith, 2010; Sigel, Benton, Lynch, & Kramer, 2013). This suggests that interventions should target counselor education through training programs, such as an internship program (Layne et al., 2014). A systems-contextual (SC) perspective asserts that addressing training, therapist, client, and organizational factors can result in improved therapist adherence and client outcomes (Beidas & Kendall, 2010).

Training factors include the quality of a workshop or training program and depend on its availability, content, and method of training (Beidas & Kendall, 2010). Content should be provided using active and problem-based learning that builds on the counselor's previous knowledge, incorporates a variety of instructional techniques, presented over time, and allows practice of skills (Beidas & Kendall, 2010; Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009; Chu et al., 2015; Couturier et al., 2014; Dolmans, De Grave, Wolghagen, & van der Vleuten, 2005; Draganski et al., 2004;

Ghafoori & Davaie, 2012; Herschell, Reed, Mecca, Kolko, 2014; Knowland & Thomas, 2015; Stuart, Tondora, Schoenwald, Sheidow, & Letourneau, 2004). Therapist factors, such as clinical experience, theoretical orientation, and attitudes toward EBTs can impact their ability to effectively implement a TF-EBT; however, training on TF-EBTs can ameliorate any negative impact of theoretical orientation on therapist attitudes toward TF-EBTs (Allen et al., 2014; Beidas & Kendall, 2010). Client factors (i.e., severity of symptoms and risk factors) can also impact implementation of TF-EBT; therefore trainers and supervisors need to consider their impact on treatment outcomes and assess client's appropriateness for treatment (Beidas & Kendall, 2010). However, consultation and support can improve client outcomes regardless of client variables due to improved therapist competency and higher levels of adherence (Beidas & Kendall, 2010). Organizational component, such as clinical supervision, consultation, and organizational support can improve implementation and success of TF-EBTs (Beidas & Kendall, 2010).

The research suggests that counselors interested in working with trauma victims would improve their competency to provide TF-EBTs by participating in a trauma-focused internship training program that contains multiple components and provides intensive training and experience (Beidas & Kendall, 2010). Several training components can improve counselor competency to provide TF-EBTs. These include treatment manuals, workshops, supervision, and consultation, which will address all four areas of the SC perspective and can be implemented in an internship training program (Ebert, Amaya-Jackson, Markiewicz, Kisiel, & Fairbank 2012; Herschell, Kolko, Baumann, & Davis, 2010). By training more counselors to provide TF-EBTs, more victims can have access to high quality services to help them heal.

Method

A mixed methods study of a multi-case study was used due to the small sample size, to allow for a more in-depth understanding of the how the intervention works and to pilot the assessment measure (O'Leary, 2013). Participants were graduate students in psychology (clinical, counseling, or community mental health) in the Baltimore area.

The treatment consisted of participation in the trauma-focused internship program, which included multiple components: training sessions, supervision, observation, and practice with feedback. Trainees received trainings on TF-EBTs using strategies from the learning sciences (Beidas & Kendall, 2010; Layne et al., 2014). Students were trained using the Integrative Treatment for Complex Trauma (ITCT) model with one 60-minute session for each of the following components: understanding complex trauma, assessment, advocacy, therapeutic relationship, safety, affect regulation, identity development, psychoeducation, cognitive and emotional processing, relational processing, behavior self-control, interventions with caregivers, family therapy, and self-care (Lanktree & Briere, 2008). Each trainee had 6-8 therapy cases in order to practice their trauma-focused skills. Trainees then discussed cases in individual and group supervision to obtain feedback to improve their skills (Couturier et al., 2014; Ghafoori & Davaie, 2012; O'Byrne & Rosenberg, 1998). Trainees also received on-going consultation as needed from their supervisor and the team (i.e., psychiatrist, psychologist, marriage and family therapist, licensed clinical professional counselor, consultant, and pediatrician). Trainees and supervisors were given the Trauma-Focused Counseling Competency Assessment (TF-CCA) Self and Supervisor scales at the beginning, mid and at the end of internship to assess for changes in their competency. Also, the researcher

met with the trainees and the supervisors for semi-structured interviews at the end of the internship. Trainee and supervisor feedback was very positive for both the training programs and the assessment measure. Results from the assessment measure showed that trainees demonstrated significant improvement in their competencies from pre to mid assessment. The scores then decreased slightly at the final assessment despite reports that competency improved. The decreased scores may relate to increasing expectations, although with such a small sample size the validity of the measure cannot be determined. Through the study, a treatment curriculum and assessment measure were created and piloted. From here, further research can be done to validate the measure and to determine if the training program is effective at increasing competency with a larger sample size and if the competencies would be maintained at follow-up. Also, the training curriculum could be applied to a variety of formats to teach counselors and other clinicians the competencies that are needed to treat complex trauma.

Chapter 1: Literature Review of Child Maltreatment Counseling

Community-based counselors are not fully implementing trauma-focused evidenced-based treatment (TF-EBT) for victims of child maltreatment (Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013). This leaves many victims without appropriate intervention. While there are many possible causes, this chapter outlines factors related to clients' traits, resources, counselor traits, and counselor education with an emphasis on counselor competency. The lack of knowledge and skills in child and trauma therapy are apparent in students from various graduate programs. In fact, there is a dearth of knowledge related to the field of child maltreatment, which has been a common phenomenon throughout the history of counseling (Myers, 2008; Ringel & Brandell, 2011).

The Society for Prevention of Cruelty to Children was founded in 1875, leading to a movement of nationwide non-governmental societies for child protection (Myers, 2008). Around this time, doctors first noted the impact of abuse on adults (Ringel & Brandell, 2011). In the early 1900's, when counseling emerged as a field, the Great Depression led to the disappearance of the non-governmental child protection societies, thus leaving many children unprotected (Myers, 2008; Savickas, 2011). It was not until the 1960's that all states had child welfare services and mandatory reporting laws (Myers, 2008). The history of the child maltreatment field documents neglect by the American society, which has been mirrored in the field of counseling (Romano, Goh, & Wahl, 2005). Currently, researchers estimate that almost one in five children experience some form of child maltreatment in their lifetime (Finkelhor, Turner, Ormrod, & Hamby,

2009). With such a high prevalence rate, it is likely that any counselor working with children will encounter victims of maltreatment.

Theoretical Perspectives

As sociologists are concerned with the roles and relationships in society and factors that determine outcomes, sociological research examined the impact of abuse and neglect on victims (Francis, 2009). Several studies link histories of child maltreatment with a variety of negative consequences (Felitti et al., 1998; Herrenkohl, Hong, Klika, Herrenkohl, & Russo, 2013; Taylor, et al. 2008). Taylor, et al. (2008) interviewed 60 young adults in a homeless shelter and found that victims of child abuse had a greater risk of exposure to other violence such as additional child abuse, intimate partner violence, and community violence. Felitti et al. (1998) conducted the seminal Adverse Childhood Experiences (ACE) study on over 1,300 patients, which revealed that exposure to any one category of adverse experiences – such as experiences of child maltreatment – increased the likelihood of exposure to other categories of adverse experiences, thus corroborating the findings from Taylor et al. (2008). Also, increased numbers of adverse experiences positively correlate with prevalence and risk of smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, illicit drug use, number of sexual partners (>50), and history of sexually transmitted diseases (Felitti et al., 1998). Herrenkohl et al. (2013) conducted a longitudinal study in which they interviewed 457 people and also demonstrated that those with histories of child abuse experienced more depression, anxiety, health problems, and alcohol and substance use in adulthood. Sociological research confirmed the link between experiences of child maltreatment and mental health issues later in life (Felitti et al., 1998; Herrenkohl et al., 2013).

Economists, however, focus on how limited resources are used in order to meet demands (Vignoles, 2009). Through this lens, economists addressed issues related to counselor competency and availability of treatment resources. Economics research examined issues related to limited financial resources, cost-benefits of therapy, and the supply of TF-EBTs (Vignoles, 2009). Child maltreatment is widely considered a costly problem, although researchers vary considerably on the actual cost determination (Conrad, 2006; Fang, et al., 2012). The lifetime costs include expenses related to health care (physical and mental health), productivity loss, child welfare, criminal justice, and special education and range from $210,000 to $6,055,675 (Conrad, 2006; Fang et al., 2012). The estimates rise sharply when one considers that these numbers only account for substantiated cases and do not include full costs such as reduced life expectancy, decreased quality of life, and the negative effects of the subsequent poor parenting on victims' children (Fang et al., 2012). The cost of child maltreatment provides a strong argument for the need to fund services for victims; however, one must determine if the time and money invested in treatment yields worthy results for victims and if victims are able to access evidence-based services.

Problem of Practice

In 2015, Child Protective Services received approximately 4 million referrals, which included 7.2 million children, for concerns of child abuse or neglect (USDHHS, 2017). The negative consequences of maltreatment reach across all aspects of victims' lives including mental, medical, financial, legal, educational, and social functioning (Fang et al., 2012). There are cost-effective treatments that have been shown to reduce trauma-related symptoms; however, most counselors are not using these evidence-based

treatments (EBTs) (Borntrager et al., 2013; Gospodarevskaya & Segal, 2012). Therefore, many victims of child maltreatment are not receiving the quality mental health treatment than can help them heal. There are a variety of factors that could be related to the treatment that victims receive, including client traits (Cohen & Mannarino, 2000; Lohman et al., 2004), limited resources (Borntrager et al., 2013), counselor traits (Allen, Gharagozloo, & Johnson, 2012; Driscoll et al., 2003), and counselor education (Allen, Wilson, & Armstrong, 2014; Nelson & Graves, 2011).

Review of the Literature

Client Traits

How well a child can benefit from mental health treatment may, in part, depend on their own traits. Although experiences of child maltreatment correlate with a variety of negative outcomes, individual, family and cultural characteristics can mediate the effects (Cohen & Mannarino, 2000; Felitti et al., 1998; Widom, Czaja, Wilson, Allwood, & Chauhan, 2012). Client traits can include socioeconomic status, age, intellectual functioning, family dynamics, engagement in the therapeutic process, and race/culture (Cohen & Mannarino, 2000; Hanson et al., 2013; Lohman et al., 2004; Widom et al., 2012).

Socioeconomic status. Low socioeconomic status (SES) places children at-risk for intellectual, emotional, and behavioral difficulties (Lohman et al., 2004; Santiago, Wadsworth, & Stump, 2011). Santiago et al. (2011) conducted a longitudinal study of 98 families (300 individuals) using questionnaires and interviews. Using a hierarchical linear model, researchers demonstrated that low-SES correlated with emotional and behavioral problems in children, including anxiety, depression, and poor social skills (Santiago et

al., 2011). Lohman, et al., (2004) added to this research by comparing families' receipt of welfare services to child outcomes (i.e., emotional, behavioral, and intellectual issues). Researchers interviewed 2,402 randomly selected, low-income children and caregivers in low-income neighborhoods in Boston, Chicago, and San Antonio (Lohman et al., 2004). Results indicated that children of current and recent welfare recipients had lower intellectual skills and more behavioral problems compared to those that never received services or had not received services for over two years (Lohman et al., 2004). While these emotional, intellectual, and behavioral outcomes place children at higher risk for maltreatment, Zielinski (2009) analyzed the results from surveys of 5,877 people in the US and linked experiences of child maltreatment to poor adult SES-related outcomes. Thus, experiences of child maltreatment and SES are interrelated and may lead to other symptoms that complicate treatment.

Race and ethnicity. Widom et al. (2012) examined the relationship between race/ethnicity and the impact of maltreatment. Victims of substantiated abuse or neglect were matched with subjects who did not have a reported history of maltreatment. Researchers conducted double-blind interviews with 1,039 adults to assess for various intellectual, occupational, and mental health outcomes (Widom et al., 2012). The results were indicative of a significant impact of race, at times leading to worse consequences and at other times mediating the effects (Widom et al., 2012). Their findings included more mental health consequences for Whites, arrests for Blacks, and alcohol abuse for Hispanics (Widom et al., 2012). Researchers noted that possible confounding variables included child, family, or neighborhood characteristics as well as trauma experiences (Widom et al., 2012).

Family characteristics. Researchers have argued that child and family characteristics can impact treatment outcomes (Cohen & Mannarino, 2000; Hanson et al. (2013). Cohen and Mannarino (2000) conducted a study to examine the impact of child and family characteristics on the effects of childhood sexual abuse. Researchers randomly assigned 49 victims (ages 8-14) to one of the two treatments for 12 weeks of therapy. Pre- and post- measures of psychological symptoms and child and family characteristics were compared. The children's perceptions of being believed and family hyper-adaptability were found to correlate with treatment outcomes (positively and negatively, respectively). While Cohen and Mannarino (2000) focused specifically on sexual abuse victims, Hanson et al. (2013) confirmed that caregivers' traits – specifically, their own mental health needs and lack of "buy in" to treatment – can negatively impact treatment for a variety of trauma experiences.

Client traits can serve as risk or protective factors for the effects of maltreatment and the impact of treatment. Poverty is a risk factor while family support is a protective factor (Cohen & Mannarino, 2000; Santiago et al., 2011). As Widom et al. (2012) noted, race can have both positive and negative effects. Family support and adaptability as well as caregivers' mental health status and engagement in treatment are key factors that determine the impact of treatment (Cohen & Mannarino, 2000; Hanson et al., 2013). The impact of clients' traits on counseling assumes that victims of maltreatment have access to appropriate counseling services. Therefore, another area to explore is the availability of trauma-informed counseling.

Resources

Economics research examines issues related to limited financial resources, cost-benefits for therapy, and the supply of TF-EBTs (Vignoles, 2009). Child maltreatment is widely considered a costly problem; however, evidence-based treatments to help them heal and minimize the negative impact are limited (Borntrager et al., 2013; Conrad, 2006). Economists have examined both the cost-benefits and the availability of TF-EBTs (Borntrager et al., 2013;Gospodarevskaya & Segal, 2012).

Cost-Benefits. Limited financial resources can be a barrier to access and provision of treatment. Therefore, the cost of providing EBTs is an important factor and should include the costs of the treatment and required training. Outpatient trauma-focused (TF) counseling costs about $2000 per victim, which may be cheaper than doing nothing (Greer, Grasso, Cohen, & Webb, 2014; Gospodarevskaya & Segal, 2012). Gospodarevskaya & Segal (2012) conducted a cost-benefit analysis comparing trauma-focused cognitive-behavioral therapy (TF-CBT) with and without the use of selective serotonin reuptake inhibitors (SSRI) and non-directive therapy at 12-month follow-up. They found that TF-CBT is the most cost-effective; however, any treatment was better than no treatment. Le et al. (2014) confirmed those findings when they demonstrated the cost-effectiveness of prolonged exposure (a TF-EBT). While providing TF-EBTs is expensive, it is more cost effective than general counseling or not providing any treatment (Greer, Grasso, Cohen, & Webb, 2014; Gospodarevskaya & Segal, 2012, Le, Doctor, Zoellner, & Feeny, 2014). Greer et al. (2014) noted that victims who do not receive TF-EBTs end up needing more intensive and expensive treatments. Researchers, however, did not add in the costs of training for the therapist to the costs of treatment.

This is an important factor as Sigel et al. (2013) determined that state-level programs to disseminate TF-CBT cost about $500,000 a year, which is $6000 to $10,000 per therapist. Research was not found that examined the cost effectiveness and costs of training for other TF-EBTs. Although researchers noted that treatment prevents future symptoms, thus reducing the financial impact of maltreatment, no studies were found that directly examined that assumption.

Availability of services. Another economic concern is the supply of TF-EBTs. Most community-based counselors are not using TF- EBTs to treat child victims, which limits the availability of TF services (Borntrager et al., 2013). While some argue that clinicians do not have the proper training on TF-EBTs, others claim that regardless of training, counselors are not effectively implementing all components of the TF-EBTs (Borntrager, et al., 2013; Kolko et al., 2009). Borntrager et al. (2013) collected data on 814 traumatized children treated in a community-based mental health system. They found that most therapists used techniques that are not TF and did not include core trauma-focused interventions (Borntrager et al., 2013). Kolko et al. (2009) also looked at community-based counselors; however they surveyed counselors (n=401) who had been trained in TF treatment. Despite their training and ability to identify the most important components of trauma treatments, counselors relied most frequently on interventions that were not TF (Kolko et al., 2009). Sigel et al. (2013) found several barriers related to implementing TF-EBTs, including time, money, and staffing, however no studies noted the impact of therapists' caseloads in the community setting. While economic research indicates that therapists are not implementing TF-EBTs effectively, the studies did not focus on the reasons. Sociological studies, on the other hand, have expanded on this

research by exploring counselor traits that impact their use of TF-EBTs (Sigel et al. (2013).

Counselor Traits

As previously noted, economics research confirms that counselors are not implementing TF-EBTs (Borntrager et al., 2013). Sociological research addresses why counselors are not using TF-EBTs by examining counselor traits. Sigel et al. (2013) found that barriers to implementation of TF-EBTs included therapists' difficulty determining appropriate clients, opposition to manualized treatment, and resistance to discussing trauma. The majority of the research, however, focuses on counselor traits related to their knowledge, theoretical orientation, and experience.

Knowledge. Counselors do not possess sufficient knowledge of EBTs or how to implement them (Allen, et al., 2012; Hanson et al., 2013). Allen et al. (2012) used data from a nationwide survey – the Treatment Attitudes, Perceptions, and Practices for Neglected and Abused Children (TAPPNAC) – to analyze 240 clinicians' responses. Results indicate that clinicians, regardless of experience, degree, theoretical orientation, and professional setting, were unable to differentiate between EBTs and non-EBTs and most clinicians used non-EBTs (Allen et al., 2012). Hanson et al. (2013) added to this research by surveying trainers (n=19) to determine what factors prevent implementation of EBTs with children. Most trainers felt that counselors were not implementing the necessary components due to a lack of clinician competence (understanding and skill), especially related to cognitive therapy, cognitive restructuring, and exposure (Hanson, et al.). While the sample size was small, other research also identified a lack of both skills and knowledge for counselors (Borntrager, et al., 2013; Hanson, et al., 2013; Kolko et al.,

2009). Therefore, counselors are not knowledgeable in the various TF-EBTs as well as the specific components of trauma-focused counseling (Borntrager, et al., 2013; Hanson, et al., 2013).

Theoretical orientation/beliefs. Other research has focused on the impact of therapists' beliefs about treatment, which tie into their theoretical orientation, as they have a direct impact on which types of counseling interventions are used to treat trauma (Allen & Crosby, 2014; Sigel, et al., 2013). To examine the impact of counselors' beliefs on intervention selection, Allen and Crosby (2014) used data from the TAPPNAC, a nationwide survey of clinicians. Researchers surveyed 256 clinicians working with child maltreatment victims to assess their beliefs about structured treatment, which reflected their theoretical orientation, and treatments. Clinicians portrayed a slight preference for non-directive approaches such as play/ expressive or supportive therapy, and seemed to question if children have the ability to verbally process their trauma, which is a key component of TF-EBTs (Allen & Crosby, 2014). This corresponds with findings from Sigel et al. (2013) in which therapists' resistance to manualized treatment was a barrier to implementation of TF-EBTs. Allen and Johnson (2012) confirmed the importance of counselor's beliefs, noting that theoretical orientation was a better predictor of TF-EBT implementation than discipline, age, or experience (Allen & Johnson, 2012).

Experience. Research on the impact of counselor experience on client outcomes is mixed and does not address clients with specific treatment needs such as trauma. Driscoll et al. (2003) examined the impact of varying levels of trainee experience on outcomes of 83 adult clients in an outpatient community mental health center. Patients were randomly assigned to doctoral level trainees who provided treatment (Driscoll et al.,

2003). Results indicated that more experience resulted in improved client outcome; however, all clinicians were in-training, thus the differences noted may not apply to those who have completed their education (Driscoll et al., 2003). Nyman et al. (2010) also examined the impact of counselor training level on the effectiveness of treatment; however, they used a multi-tiered training system which included counselors with varying levels of degrees and experiences and higher-level counselors supervising lower level trainees. Clients (264 college students) completed validated symptoms measures (i.e., College Adjustment Scale and the Outcome Questionnaire) which showed that clients had reduced symptoms that were not impacted by counselors' experience or degree level (Nyman et al., 2010). It is difficult to compare the results of the two studies: Driscoll et al. (2003) had a smaller sample size and only used doctoral-level trainees, although the clients were actual patients in a community mental health center. In contrast, the study by Nyman et al., (2010) had a much larger sample size and used counselors with varying levels of education/training, thus providing for more generalizability. One limitation is that clients were college students instead of patients seeking treatment, which may limit the relevance of the results. Therefore, therapist experience may impact the quality of treatment; however, it is unclear what aspects of therapy mediate the impact of experience such as supervision, training, or type of treatment.

Counselors' experience may or may not impact treatment, but their beliefs about how therapy should be structured, theoretical orientation, and training do (Allen & Johnson, 2012; Driscoll et al., 2003; Hanson et al., 2013; Nyman, et al., 2010; Sigel et al., 2013). Therapists who believe that children can and should verbally process their trauma and those subscribing to more cognitive-behavioral orientations are more likely to use

TF-EBTs, which tend to be manualized (Allen & Johnson, 2012; Sigel, 2013). It is interesting to note that none of the researchers asked the therapists directly about why they may not adhere to TF-EBT guidelines. The research also did not examine the impact of counselor education on the use of TF-EBTs.

Counselor Education

Sociological researchers have argued that counselors lack the competency to provide TF-EBTs to child victims of maltreatment (Hanson et al., 2013). Counselors gain their knowledge and skills from their graduate programs, trainings, and supervision. It is important to note that licensure and accreditation requirements do not require any knowledge related to trauma or child therapy (CACREP, 2009; DHMH, 2013). Counselors' competency may depend on their graduate program, but if master's degree programs are not offering sufficient courses related to treating traumatized children, then counselors are depending on post-graduate training and supervision to provide the needed knowledge and skills. Therefore, both graduate programs and training/supervision are important elements in counselor education.

Graduate programs. No research was found that assessed master's degree program's ability to effectively prepare counselors to treat child victims of maltreatment specifically. Also, licensing and accreditation agencies do not require separate trauma coursework (CACREP, n.d.; DHMH, 2013). Nelson and Graves (2011) assessed general competencies through a survey of approved marriage and family therapy supervisors (n=137) to rate supervisees on core competencies such as interviewing skills, managing risks, gathering biopsychosocial history, and providing psychoeducation. The results indicated large differences between what supervisors wanted and what trainees had

mastered, although the difference was smaller for trainees from accredited programs (Nelson & Graves 2011). In fact, trainees were rated competent in only 12 of 128 core competencies by supervisors (Nelson & Graves, 2011). Haberstroh, Duffey, Marble, and Ivers (2014) also found that evaluations of counseling skills as assessed by site supervisors revealed gaps in trainees' competencies. This suggests that graduates from master's degree programs may not be competent in basic counseling skills, although it was unclear if the discrepancy was due to inappropriate expectations by supervisors. If programs are unable to ensure graduates are competent in basic counseling skills, then it seems unlikely that they could adequately teach the advanced skills needed for treating child victims. This increases the importance of post-graduate training for counselors.

Training. Master's-level counselors, however, do not get adequate training on EBTs (Allen et al., 2012). Based on results from the TAPPNAC nationwide survey, 240 clinicians were unable to differentiate between EBTs and non-EBTs regardless of experience, degree, theoretical orientation, and professional setting (Allen et al., 2012). Two themes arose. First, most clinicians were trained on TF-CBT, but not other EBTs (Allen et al., 2012). Also, clinicians received more training on therapies that are not EBTs than those that are EBTs (Allen et al., 2012). However, training on an intervention increased the chance that it will be used (Allen et al., 2012). Allen et al. (2014) surveyed 29 clinicians and discovered that intensive training on TF-CBT can impact counselors' beliefs about how to conduct treatment. Counselor beliefs were assessed before and after completing a TF-CBT training program and compared to the 18 clinicians who did not receive the training (Allen et al., 2014). After the training program, trainees showed a large change in their beliefs about TF treatments compared to the waitlist group,

including increased beliefs that structured treatments are important and that children are able to verbally process their traumas (Allen et al., 2014).

Counselors not only receive inadequate training related to TF-EBTs, but they also appear to lack basic counselor competencies (Allen et al., 2012; Nelson & Graves, 2011). No studies were found, however, that examined what information students obtain in masters' degree psychology programs related to TF-EBTs for children. It does appear that training can reduce counselors' resistance to TF-EBTs, but counselors still fail to implement TF-EBTs with high fidelity (Allen & Johnson, 2012; Allen et al., 2014).

Conclusion

Child maltreatment has devastating effects that can be minimized with TF-EBTs. Many children who experience maltreatment are unable to gain access to the appropriate services due to client traits, limited resources, counselor traits, and education of counselors (Allen et al., 2012; Allen et al., 2014; Borntrager et al., 2013; Cohen & Mannarino, 2000; Driscoll et al., 2003; Lohman et al., 2004 Nelson & Graves, 2011). As counselors are unable to change client traits, solutions should target the counselors themselves. Researchers argue that a lack of training on TF-EBTs is a key factor in the limited supply of effective intervention for victims of maltreatment (Allen & Johnson, 2012; Borntrager, et al., 2013; Driscoll et al., 2003; Hanson et al., 2013; Kolko, et al., 2009; Nyman, et al., 2010; Sigel et al., 2013). In fact, training on TF-EBTs reduces the negative impact of counselors' theoretical orientation and experience on implementation of TF-EBTs (Allen, Wilson, & Armstrong, 2014). This suggests that interventions should target counselor education through training programs.

Numerous studies examine the impact of maltreatment to support various interventions (Allen & Crosby, 2014; Gospodarevskaya & Segal, 2012). While research exists about the effectiveness of TF-CBT including therapist competency and use of TF-CBT, there is little related to other TF-EBTs. Also, research on the reasons that EBTs are not being used seems based on assumptions regarding lack of training and theoretical orientation, but does not address client presentation and caseload impacts. Other possible drivers to explore include client attendance, lack of parental involvement, intellectual or verbal limitations of the child, trauma that occurs pre-verbally (thus verbal memories are not available), the presence of other confounding symptoms, and psychosocial stressors. Research on these factors was lacking. Although studies clearly document that community-based clinicians are not implementing TF-EBTs, they do not examine client characteristics and their impact on treatment modalities.

Chapter 2: Needs Assessment

The present study examines the issue of competency of graduate students at the Care Clinic to effectively treat child victims of abuse and neglect (i.e., maltreatment). The Care Clinic of the University of Maryland, School of Medicine is a mental health program that provides treatment for victims of child maltreatment as well as training to other professionals on topics related to child maltreatment. As part of the training initiative, the Care Clinic serves as a placement for masters and doctoral students in clinical and counseling psychology to teach them about child maltreatment and how to provide effective mental health intervention. In order to improve the training program, information is needed on the relevant knowledge and coursework that students are getting in their educational programs. The Care Clinic will then develop its training program to address any gaps in knowledge of trauma treatment.

Key Concepts

In order to fully explore the issues of counselor competency to treat child victims of maltreatment, there are several key concepts that first need to be defined. For the purposes of this paper, child maltreatment refers to child physical, sexual, and psychological abuses and neglect. Code of Maryland Regulations (Maryland DHR, n.d.) defines child abuse and neglect as physical injury or failure to give proper care and attention to a child, acts involving sexual molestation or exploitation, or impairment of a child's mental or psychological ability to function.

This paper focuses on trauma-focused evidenced based treatments (TF-EBTs), which include core trauma-related components, but also have research that support their effectiveness. The National Childhood Traumatic Stress Network (NCTSN, n.d.)

identified several key components of TF-EBTs for children, including psychoeducation, managing stress reactions, trauma narratives, coping skills, parenting skills, and safety planning. Much of the literature focused on trauma-focused cognitive-behavioral therapy (TF-CBT), but NCTSN identified several other TF-EBTs that are effective for a wide range of traumas including child maltreatment, such as Dialectical Behavioral Therapy for Special Populations (DBT-SP); Attachment, Self-Regulation, and Competence (ARC); Child and Family Traumatic Stress Intervention (CFTSI); Child Parent Psychotherapy (CPP), Integrative Treatment of Complex Trauma (ITCT); Parent-Child Interaction Therapy (PCIT); and Safety, Mentoring, Advocacy, Recover, and Treatment (SMART) (NCTSN, n.d.). For the purpose of this study, counselor competency includes both knowledge and ability to apply skills effectively. It is important to note that the present study focuses on students in master's degree programs in counseling or clinical psychology.

Stakeholders

The most important stakeholders are the children and families that have experienced maltreatment and need mental health services to help them heal. Referral sources such as departments of social services, child advocacy centers, schools, and pediatricians also have a vested interest in the quality of services that are available to the victims of maltreatment that they serve. All of the Care Clinic staff take part in the training of interns and have expressed a strong desire to help victims of maltreatment and to train other professionals to improve services to victims. Both the local universities and the students depend upon internship sites such as the Care Clinic to provide quality training to students so that they may be able to effectively provide counseling services

upon graduation. Therefore, the quality of training that interns receive is of great import to victims, referral agencies, the staff at the Care Clinic, graduate students, and the local graduate programs.

Goals and Objectives

While research suggests that counselors lack sufficient knowledge of TF-EBTs, there was little research that addressed why the knowledge is lacking (Allen et al., 2012; Hanson et al., 2013). One possibility is that students are not taught about trauma treatment in graduate school. Therefore, the purpose of this needs assessment is to determine what students do learn in graduate school relating to treating child victims of maltreatment.

Research Questions

Q1: What courses do students take related to trauma therapy and therapy with children?

Q2: What knowledge do master's-level counselors possess relating to trauma symptoms and TF-EBTs?

Q3: How have past interns rated the training they received at the Care Clinic in the following areas?

Q3a: Amount of training

Q3b: Helpfulness of training

Q3c: Quality of supervision

Methods

Description Setting and Respondents

The Care Clinic training program is located in an outpatient mental health practice at the University of Maryland, School of Medicine in Baltimore, MD. There are four universities in the Baltimore area that have master's degree programs in clinical or counseling psychology. Interns typically come from three of the four local universities, though surveys were sent to all four.

There were three different groups of respondents: Eighteen second-year, masters level graduate students completed an online survey. These students were mostly white (94.4%) females (88.9%). The majority of the students were between 18-29 (70.6%) or 30-44 (23.5%) years old and attended one of three universities. No responses were received from the fourth university. Faculty from two universities also answered a survey. One faculty is director of the clinical psychology program and the other faculty was a director of the field education for both the counseling and clinical psychology programs at a second university. Lastly, internship surveys had previously been given to six interns at the Care Clinic. Interns were also second-year psychology students.

Variables

Variables include child trauma therapy coursework, knowledge of trauma, and knowledge of TF-EBTs. Child trauma therapy coursework included courses on trauma and courses on child therapies. Knowledge of trauma included the ability to identify traumatic events and the criteria for posttraumatic stress disorder (PTSD). TF-EBTs were taken from a study by Allen, Gharagozloo, and Johnson (2012) in which they had experts

in the field identify the most and least empirically-supported treatments for child victims of maltreatment.

Data Collection Methods

To better assess students' knowledge, a variety of data collection strategies were employed incorporating existing and new data. Mixed methods have the benefit of providing a more complete picture of the problem and employing more perspectives (O'Leary, 2014).

Existing data. Existing data addressed the question of course offerings at the universities and past interns' experiences at the Care Clinic. This answered research questions Q1 regarding which courses students have taken and Q3, which seeks to understand internship training experience for Care Clinic interns.

There are four universities in Baltimore, MD that offer master's degrees in clinical or counseling psychology. Their websites outline program requirements. The websites were examined for program descriptions and course catalogs to determine what courses have been offered and are available to students. Also, the websites for the Maryland Board of Professional Counselors and Therapists and the Council for Accreditation of Counseling and Related Educational Programs outlined course requirements for licensure and accreditation.

Care Clinic interns complete surveys at the end of their placements to assess their opinions of their supervision, training, and overall experience during their placement. Interns were asked to provide a numeric rating and comments. Approximately three years' worth of surveys were available from six interns. Results from the surveys were

analyzed for trends and overall feedback. The ratings were tabulated and comments were reviewed, thus providing both quantitative and qualitative results.

New data. Mixed methods were employed to answer research questions Q1 and Q2. Surveys explored students' knowledge of TF-EBTs (Q2) and course experience related to treating child victims of trauma (Q1). Also, counselor educators completed a survey on course offerings and students registration for those courses (Q1).

Surveys for students (Appendix 1) asked what courses they took or planned to take related to child therapy and trauma (Q1). Other questions included asking students to identify events and symptoms of post-traumatic stress disorder and TF-EBTs (Q2).

Surveys of university faculty (Appendix 2) were used to provide a deeper understanding of counselor education. Faculty answered questions about course offerings including availabilities of child and trauma-based courses and how course offerings were selected. Educators also identified the types of settings in which interns and graduates work.

Both quantitative and qualitative data were incorporated to obtain a better picture of student preparation to counsel victims. On-line data identified what related courses are offered in the master's degree programs and about how past Care Clinic interns rated their internship experience. Surveys were used to better assess students' knowledge and skills related to trauma treatment and how universities determine what courses to offer and internship sites to work with.

Initial Summary of Results

Due to the small sample size, descriptive statistic were used to answer research questions. A summary of the findings is presented for each research question using both new and existing data.

Research Question 1

The first question examined the courses students take related to trauma therapy and therapy with children. Data from school, licensing, and accrediting websites confirmed that courses related to trauma and child therapy are not required. All four of the universities offered child and trauma therapy courses as electives. Figure 1 shows the number of students taking courses on trauma and child therapy courses. Out of 17 respondents, seven took a course on trauma. Nine of the 17 indicated that they took a child therapy course; however, in reviewing the course names, only three were treatment courses while the others were psychopathology or development. Faculty from two different universities noted that courses in trauma and child therapy are offered, but only as electives; therefore, students are not required to take them.

Research Question 2

Respondents demonstrated knowledge of posttraumatic stress disorder, but were unable to identify TF-EBTs (Figures 2-4). Out of four traumatic experiences, 100% of respondents were able to identify three of them and 94% identified the fourth example. Only 25% of respondents selected incorrect examples. Each of the correct PTSD criteria were identified by 87-100% of respondents.

On the list of therapy interventions, most respondents were able to identify two of the five TF-EBTs: Trauma-focused (14 of 17, 82%) and abuse-focused (10 of 16, 63%)

cognitive-behavioral therapy. There were three other TF-EBTs listed; however, most students were not able to identify them as such (child-parent psychotherapy – 2 of 16, 13%; positive parenting program – 3of 16, 19%; parent-child interaction therapy – 5 of 17, 29%). Of note, most students appeared to know that the remaining 10 interventions listed were not TF-EBTs as they were not endorsed by most students (0-5 students selecting each).

Research Question 3

Intern surveys included questions on the placement as a whole, the training program, and supervision (Figure 5). Students were asked to respond to statements with ratings of either zero (not applicable) or from one (strongly disagree) up to five (strongly agree), with higher numbers reflecting more positive ratings. The mean rating for the placement was 4.8 (range 4-5), the training program was 4.67, (range 3.5-5) and supervision was 4.86 (range 4.17-5).

Discussion

Child maltreatment is prevalent and has many negative effects on victims (Felitti et al., 1998; Finkelhor, Turner, Ormrod, & Hamby, 2009). There are treatments that are cost effective (Gospodarevskaya & Segal, 2012). Counselors, however, seem to lack competency to provide those treatments (Hanson et al., 2013). This study attempted to determine what information students gain through their master's degree programs. In order to get a complete understanding of what courses students take and what they know about trauma treatment for children, quantitative and qualitative data was used.

The results highlight a lack of awareness of TF-EBTs. Despite the fact that most students appear to have knowledge of trauma, they were not able to identify most of the

TF-EBTs. It is unclear if they would have been able to identify the core components of trauma therapy. Of the two TF-EBTS identified by most students, both had names that clearly reflected a trauma focus and cognitive behavioral therapy, which is widely considered evidenced-based. Also, all of the universities offered courses on child and trauma therapy, but most students did not take the course. This may explain their inability to identify most of the TF-EBTs. The results suggest that most graduate students in clinical and counseling psychology do not obtain sufficient information from their programs to provide effective treatment to victims of child maltreatment; therefore, the internship program will have to provide the necessary information and training.

There are several limitations. First, there was a very low response rate. Only 18 students completed the survey and several questions were skipped by one to two respondents. Also, one of the four universities did not respond at all. The small response rate not only limited the possible types of statistical analysis, but prevents any generalizability of results. A second limitation is that the survey did not ask about internship experience, thus it is unclear if students gained information on trauma treatment from their coursework or internship experience. Also, there were no questions that asked students about the core competencies of trauma treatment. Lastly, the survey only investigated student knowledge, not skills. In order to provide effective treatment, knowledge is not sufficient: Counselors must be able to apply that knowledge.

Future research will need to address how to train counselors on TF-EBTs. Measures of competency should include both counselor knowledge and skills and should be assessed pre and post training. Another question that is beyond the scope of this needs

assessment is to identify the various factors that prevent use of TF-EBTs once counselors are trained.

Chapter 3: Review of Trauma-Focused Counselor Training

Child maltreatment is rampant in the United States with almost one out of five children experiencing at least one form of maltreatment over their lifetime (Finkelhor, Turner, Ormrod, & Hamby, 2009). With such a high prevalence rate, many people seeking counseling services are likely to have a history of child maltreatment. Currently, all but one state does not require that counselors take a distinct course on trauma for licensure (Counselor License, n.d.). It is not surprising, then, that most counselors working with victims are not using trauma-focused evidenced-based treatments (TF-EBTs), resulting in limited availability of effective treatment services for victims (Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013). This paper briefly examines the factors that negatively impact the counseling services that victims of child maltreatment receive with a special emphasis on counselor education. A review of the literature on counselor education and training is presented followed by a proposed intervention to improve counselor competency to treat victims and therefore increase their access to quality services to help them heal.

Literature Review

One way to improve victims' access to service is to ensure that more counselors can provide the needed services, which can be done via an internship training program for graduate students in psychology (Layne et al., 2014). In order to create an effective training program, several questions should be considered. First, what are necessary training components to encourage therapist competency in TF-EBTs? Second, what are the core trauma competencies that should be taught? Lastly, how does one measure

therapist competency? Each of these questions will be explored and then related to an intern-training program in trauma treatment.

Training Components

A systems-contextual (SC) perspective asserts that addressing training, therapist, client, and organizational factors can result in improved therapist adherence and client outcomes (Beidas & Kendall, 2010). Sigel, Benton, Lynch, and Kramer (2013) conducted a large-scale study in which they explored dissemination efforts for a TF-EBT. Their results supported the SC perspective. Based on their interviews with lead staff, they found that barriers to implementation include training elements such as who the trainers were; therapists factors such as therapists' resistance to manualized treatment and discussing trauma and therapists' ability to determine appropriate clients; clients' appropriateness for treatment; and organizational issues, including staff turnover and time and productivity limitations (Sigel et al., 2013). Several training components can improve counselor competency to provide TF-EBTs, such as treatment manuals, workshops, supervision, and consultation, which will address all four areas of the SC perspective (Ebert, Amaya-Jackson, Markiewicz, Kisiel, & Fairbank, 2012; Herschell, Kolko, Baumann, & Davis, 2010).

Quality of training. The quality of a workshop or training program depends not only on its availability and content but also on the method of training (Beidas & Kendall, 2010). Research from the learning sciences and on dissemination and training models identifies several elements to improve learning and efficacy. These include various instructional methods, program layout (i.e., modular versus step programs), and training components.

Herschell et al. (2009) studied the impact of instructional strategies by examining the effectiveness of treatment manuals and workshops for disseminating an EBP. The authors assigned therapists to didactic or experiential training groups based on matching from the agency. Therapists (n=42) were community-based clinicians from 13 community-based agencies. After reading the manuals, both the didactic and experiential groups of participants received the same information in a different format: didactic (viewed sessions, discussed skills, and coded, but no practice) and experiential (role-plays, practice with feedback). Researchers conducted behavioral observations of skills and the therapists completed self-reports to measure their characteristics, knowledge gain, and satisfaction. Participants completed a pre-training assessment and follow-up assessments at different stages of the training program. Results suggest that reading manuals is only minimally helpful. Experiential and didactic training equally improved knowledge, skills, and satisfaction, which matches the results of Dicksen and Jepsen (2007), but the two-day training was not sufficient for the majority of clinicians to demonstrate mastery (Herschell et al., 2009). The study highlights that reading manuals and attending a workshop are insufficient (Herschell et al., 2009), which could support the notion of an ongoing, multi-component training program such as an internship.

While both experiential and didactic training can improve therapists' knowledge, skills, and satisfaction (Herschell et al., 2009), interactive learning and creative problem solving are important to promote learning, therapist adherence, and improved client outcomes (Beidas & Kendall, 2010; Hardiman, 2012; Herschell et al., 2014; Stuart et al., 2004). One evidence-based training method is problem-based learning (PBL). PBL is a learner-centered evidenced-based approach that uses simulated cases, self-directed

learning, learning through practice, case-based learning-in-context, and small groups to improve counselor competency (Dolmans, De Grave, Woldhagen, & van der Vleuten, 2005; Layne et al., 2014; Layne et al., 2011; Stuart, Tondora, & Hoge, 2004). Trainings should incorporate a variety of instructional techniques such as videos, small group, role-plays, and case presentations (Herschell et al., 2014).

Other researchers have explored the layout of training experiences such as step versus modular programs. Chu et al. (2015) sought to see how therapists were using EBTs after training based on the layout of the training program. They recruited 23 community-based therapists who had previously obtained intensive training and supervision in cognitive-behavioral therapy. The initial training included a 6-hour training with didactic instructions and role-plays as well as ongoing supervision to obtain feedback on taped sessions. The researchers conducted structured interviews with the therapists, which found that therapists preferred a modular-based format to select the most appropriate interventions for a client, similar to what Borntrager, Chorpita, Higa-McMillan, and Weisz (2009) found. Borntrager and colleagues (2009) conducted a longitudinal, randomized, clinical trial of 55 therapists to discover the impact of training on manualized versus modular treatment on therapist attitudes towards evidenced-based practices (EBP). The researchers found that therapists' attitudes toward EBPs significantly improved in the modular group while there was no significant change in the manual group (Borntrager et al., 2009). As attitudes toward EBP is an indicator of use (Allen & Crosby, 2014), improving therapists' attitudes will likely result in increased use of EBP. Therefore, when creating a training program, trainers should present material as modules and assess applicability and difficulty to implement to improve therapists'

receptiveness and improve use (skill and adherence) of EBPs (Borntrager et al., 2009; Chu et al., 2015).

Other beneficial training experiences include components, such as observing the supervisor, obtaining supervision, and gaining ongoing experience with feedback (Couturier et al., 2014; Draganski et al., 2004; Ghafoori & Davaie, 2012; Knowland & Thomas, 2014). Ebert et al., (2012) conducted a study on a dissemination model to implement and sustain a TF-EBT in community settings. The model incorporates three two-day interactive learning sessions and Plan-Do-Study-Act (PDSA) cycles to adapt the information to practice. Other components included training for supervisors, collaborative/topical calls related to implementation, and a collaborative intranet. Twelve community-sites were selected and included 18 administrators, 27 supervisors, and 64 clinicians. Researchers conducted an observational study and gathered process evaluations (feedback questionnaire by staff on methods), implementation evaluations (number of families served, number of sessions, amount of supervision, and skills and fidelity of implementation), and follow-up evaluations (1 year, web-based survey to ask about current practices and barriers). Almost all participants preferred having learning sessions over a period of time versus condensed and many found the intranet and the PDSA cycles were very useful. Ebert et al. (2012) found similar results when they surveyed 68 therapists providing TF-CBT to 463 youth, which was sustained at 1-year follow-up. They also received TF-CBT-specific supervision, although at a reduced frequency. All the therapists reported that participation in the collaborative, with on-going training and support, helped with implementation and sustainability; therefore, similar components should be included in an intern-training program.

Therapist variables. Therapist factors include degree types, clinical experience, theoretical orientation, attitudes toward EBTs, and level of self-efficacy. While the impact of degree type on mastery of skills is weak, other therapist factors can impact therapists' ability to effectively implement a TF-EBT, especially self-efficacy and attitudes toward EBTs (Beidas & Kendall, 2010; Herschell et al., 2009).

One therapist factor is self-efficacy to apply interventions. Layne et al. (2014) conducted a study to evaluate the impact of a training program on students' confidence to work with trauma victims and to determine which components of an educational model they find the most helpful for field readiness. The researchers used PBL, which consist of small groups of learners who work together on a sample problem. Students completed a Core Concepts Confidence measure at the end of the course. Results showed that students' confidence for applying core concepts improved. The second phase used a Gold Standard Plus Full Educational Model which included classroom instruction for core concepts, a two-day training in TF-EBT, and implementation of a TF-EBT in year-long field placement, supervised by a trained supervisor. During this phase, 576 students completed the course at nine different social work programs. Researchers used tests of self-reported confidence to apply core concepts, a course evaluation survey based on student's ability to apply the core trauma components, and a survey where students were asked to rate the impact of each of the educational components. Results were indicative of an increase in students' confidence to apply the information.

Clinicians' beliefs that structured treatments are important and that children are able to verbally process their traumas can determine their use of TF-EBTs (Allen, Wilson, & Armstrong, 2014; Beidas & Kendall, 2010). Allen and colleagues (2014)

surveyed 29 clinicians to assess their beliefs relating to trauma-focused treatments for child victims of maltreatment before and after completing a TF-CBT training program compared to 18 waitlisted clinicians. Trainings include on-line lessons, in-person sessions, and practice with consultation. After the training program, trainees showed a large change in their beliefs about trauma-focused treatments compared to the wait list group. Post-training, clinicians increased their beliefs that structured treatments are important and that children are able to verbally process their traumas. While sample sizes were small and limited to clinicians in Texas, the results match research by Allen and Crosby (2014) on the impact of clinicians' beliefs to the utilization of EBTs.

Client variables. Client factors such as appropriateness for an intervention, severity of symptoms, and risk factors can impact the likelihood that therapists will successfully implement a TF-EBT (Beidas & Kendall, 2010). Therefore, trainers and supervisors need to consider the impact of symptom severity on treatment outcomes and assess clients' appropriateness for treatment (Beidas & Kendall, 2010). There is limited research, however, on the impact of client variables on implementation of TF-EBTs. Some research suggests that consultation and support can improve client outcomes regardless of client variables due to improved therapist competency and higher levels of adherence (Beidas & Kendall, 2010).

Organizational factors. Factors such as clinical supervision, consultation, and organizational environment play a role in implementation and success of TF-EBTs (Beidas & Kendall, 2010; Ebert et al., 2012). Using the Evidence-Based Practices Assessment Scale (EBPAS) and interviews, clinicians noted the importance of support

from trainers, agencies, supervisors, and co-workers to implement TF-EBTs (Herschell, Reed, Mecca, & Kolko, 2014).

Supervision is a key factor for implementation of TF-EBTs (Couturier et al., 2014; Ghafoori & Davaie, 2012; O'Byrne & Rosenberg, 1998). Couturier et al. (2014) used a qualitative study to obtain an understanding of therapists' thoughts and beliefs about implementing a family-based EBT for anorexia and to determine the strategies and results of the interventions. Therapists (n=40) from a network that works in a variety of settings with children and adolescents with anorexia, participated in 60-90 minute semi-structured interviews. Participants suggested that supervision should be provided by an expert on the intervention to assess learning and troubleshoot. Ongoing supervision and support was recommended for the team to help with implementation and fidelity. Although this study was descriptive in nature, it supports the notion that therapists need intense training, ongoing supervision by an expert, and support of organization. The results offered many ideas for how to structure a training program and to increase counselor competency on an EBP such as TF-EBTs. They also support research by Ghafoori and Davaie (2012) who found that a strong training program, which includes supervision, results in client improvement.

Another important component of dissemination is consultation. Consultation improves counselors' competency and adherence to TF-EBTs and serves a different function than supervision in its emphasis on adherence to the treatment model (Chu et al., 2015; Schoenwald, Sheidow, & Letourneau, 2004). Karline et al. (2010) explored the role of consultation in their study on the dissemination initiative for Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) and the response from trainees. Veteran's

Affairs mental health staff participated in training on CPT or PE including workshops (3 to 4-day), consultation, and other supportive resources on an intranet. Program evaluations assessed outcomes for patients and therapists (PTSD checklist for patients and surveys for therapists). Based on survey results, therapists noted the importance of ongoing consultation to improve competency and adoption of intervention by therapists. A study on 249 therapists and 21 consultants by Schoenwald and colleagues (2004) found, however, that consultants must have a high level of competence for improved therapist adherence and child outcomes. Both studies support the notion of ongoing support and consultation (Karline et al., 2010; Scheonwald et al., 2004), which are part of an intern training program.

While supervision and consultation are important, organizational support can also have a positive impact on implementation of an intervention (Couturier et al., 2014). Research on a community dissemination effort for a TF-EBT in community settings highlighted organizational issues that impact training efforts (Pearl et al., 2011). Participants included community-based therapists (n=23) from 15 agencies in five states who attended a five-day workshop (30-hours) and consultation via conference calls and video review. Although many of the therapists learned the skills easily and client outcomes were positive, organizational issues were apparent. High therapist turnover reduced their ability to use consultation and high caseloads prevented weekly sessions and limited the therapists' availability to complete follow-up measures and consultation. Ebert et al. (2012) found similar results in their study of a collaborative dissemination to implement and sustain TF-CBT in community settings. The biggest barrier to implementation was time (productivity or other agency demands), organizational

restructuring, and staff turnover (Ebert et al., 2010). Also, program cultural ambience can impact clinician skills, awareness, and relationships (Dickson & Jespen, 2007). Therefore, organizational issues are crucial for improving counselor competence and dissemination of TF-EBTs (Dickson & Jespen, 2007; Ebert et al., 2010; Pearl et al., 2011).

Competencies

As previously noted, content is an important aspect of training quality (Beidas & Kendall, 2010). The National Childhood Traumatic Stress Network (NCTSN, n.d.) identified several key components of TF-EBTs for children, including psychoeducation, managing stress reactions, trauma narratives, coping skills, parenting skills, and safety planning. Layne et al. (2011) divided the core trauma concepts into three domains: Understanding the trauma experience (e.g., the complex processes), the consequences (e.g., involvement of the nervous system), and principals for interventions (e.g., awareness of vicarious trauma). Therefore, any training program needs to include these trauma competencies. The Care Clinic uses the Integrative Treatment for Complex Trauma (ITCT) (Lanktree, & Briere, 2013) model. This integrative model is a research-based model that has components to address advocacy and systems interventions, the therapeutic relationship, safety, distress reduction, affect regulation, self-identify, psychoeducation, cognitive and emotional processing, attachment processing, behavioral control, and parenting (Lanktree, & Briere, 2013). The ITCT model aligns with the components identified by the NCTSN and is modular as recommended by research (Borntrager et al., 2009; Chu et al., 2015). Therefore, the ITCT model will be used to train students to provide TF-EBT.

Competency assessment

To determine the impact of training, competency assessments are needed. Many of the studies on dissemination examined the opinions of therapists, supervisors, and consultants, and some used ratings by consumers. Different measures were used to determine therapist competency, if any. The following studies examined two different measures of therapist competency and determined how self-ratings compare to supervisor ratings.

Swank, Lambie, and Witta (2012) attempted to address the problem of assessing competency. They evaluated the Counseling Competencies Scale (CCS) using practicum students (n=188) and trained clinical supervisors (n=21). Supervisors were given a training DVD and then completed mid-term and final measures for each student using the CCS to evaluate the counseling skills and professional disposition after reviewing sessions. Upon analyzing the responses, internal consistency reliability was found. As there is very limited research on the psychometric properties of competency assessments and no others on the CCS, the results cannot be compared to other research. Would students' self-rating be any different?

Swank (2014) focused on comparing students' self-ratings of competency to their supervisors' ratings using the CCS. Forty-one students and 14 supervisors in a practicum course completed the CCS at mid-term and the end of the practicum course. There was a significant difference between supervisors' and students' ratings between mid-term and final assessment and between faculty. Students rated themselves higher than supervisors. These results contradict other studies (McManus et al., 2015) that found that trainees underestimate their competence.

McManus et al. (2015) expanded on Swank's research to see how therapists' self-assessment of their competency compared to supervisors' ratings. Researchers gave a Cognitive Therapy Scale (CTS) to Cognitive-Behavioral Therapy (CBT) trainees (n=64) and their CBT-accredited supervisors (n=16) to rate the trainees' competency. Supervisors provided ratings based on reviews of taped sessions. Results showed moderate correlations between trainees' and supervisors' ratings, and the supervisors' ratings were valid. Also trainees underestimated their skills compared to the supervisors' rating, especially for more competent trainees. While the results between Swank (2014) and McManus et al. (2015) differ; the studies used different measures of competency. Therefore, it is difficult to determine the best raters for therapist competency – themselves or the supervisors. Results do suggest that a training program should incorporate both self-report and supervisor ratings to obtain a more complete picture of counselor competency (McManus et al., 2015; Swank, 2014).

Leadership

Developing and implementing a research-based training program for graduate students in psychology requires many components. Although dissemination efforts can result in improved therapist adherence and competency as well as improved clients outcomes, barriers include staff turnover, organizational issues, and time/work allocation (Ebert et al., 2012; Pearl, 2011; Sigel et al., & 2013). Transformational leadership may be one solution.

As transformational administrators can positively impact student achievement, transformational leadership may improve counselor competency in a training program (Labby, Lunenburg, & Slate, 2012). Labby et al., (2012) noted that transformational

leadership includes building a shared vision with followers, inspiring followers, facilitating growth in others, having high expectations, displaying empathy, among other traits. Applying qualities of transformational leadership can help to stimulate the students intellectually, motivate them, and support them (Onorato, 2013). Also, transformational leadership can have a positive impact on job satisfaction, performance, and productivity (Tonkin, 2013), which can break down dissemination barriers of staff turnover and time/work allocation.

One of the major barriers to dissemination of EBTs was therapist turnover. Green, Miller, & Aarons (2013) conducted a study to examine the relationship between transformational leadership and risk factors for turnover – emotional exhaustion and turnover intention. After surveying 388 community mental health providers, they found that transformational leadership reduced emotional exhaustion and turnover intention, which impact staff turnover. Therefore, transformational leadership can help with dissemination efforts by reducing staff turnover.

Intervention Model

The research suggests that counselors interested in working with trauma victims would improve their competency to provide TF-EBTs by participating in a trauma-focused internship training program that contains multiple components and provides intensive training and experience (Beidas & Kendall, 2010). The Gold Standard Plus Full Educational Model includes instruction for the core concepts, training in TF-EBT, and implementation of a TF-EBT in yearlong field placement, supervised by trained supervisors (Layne et al., 2014). Kuo and Arcuri (2014) found that students who participated in a social-justice based practicum showed significant improvement in

measures of multicultural competencies and self-efficacy. Trainees demonstrated growth in their awareness and recognition of the distinct issues involved in counseling oppressed groups and in the cultural differences between themselves and clients. As the Care Clinic works with oppressed people (i.e., victims of abuse and neglect) like the placement described by Kuo and Acruci (2014), comparable benefits are expected.

The internship model is similar to the apprenticeship model for which Brown, Collins, and Duguid (1989) advocate to improve learning. A trauma-focused internship-training program that contains multiple components can improve counselor competency to provide TF-EBTs (Beidas & Kendall, 2010). Following an evidenced-based training model, the intern training program will include instruction for the core concepts of trauma treatment, training in TF-EBTs, and implementation of a TF-EBT in field placement, supervised by trained supervisors (Layne et al., 2014). Trainers will use strategies from the learning sciences. Trainees will observe supervisors and other experienced counselors and will receive group and individual supervision as well as consultation from experts. Trainees will practice skills on their own caseloads while receiving feedback from their supervisors to improve their competency (Couturier et al., 2014; Ghafoori & Davaie, 2012). Competency assessments and symptom measures will be used to evaluate the training program (McManus et al., 2015). Both self-report and supervisor ratings will be used to obtain a more complete picture of counselor competency (McManus et al., 2015; Swank, 2014). By training more counselors to provide TF-EBTs, more victims can have access to high quality services to help them heal.

Conclusion

While a variety of factors can impact provision of TF-EBTs, counselor education is the most actionable entry point in a treatment and training program. Counselors are not learning TF-EBTs in their graduate studies and even those that have attended training lack competence to provide TF-EBTs (Allen et al., 2012; Nelson & Graves, 2011; Rectanus, 2015). Research has identified several training components that can improve counselor competency to provide TF-EBTs. A SC perspective identifies training, therapist, client, and organizational factors that, if all are addressed, can improve therapist adherence and client outcomes (Beidas & Kendall, 2010).

The quality of a workshop or training program depends on its availability, content, and method of training (Beidas & Kendall, 2010). Content should be provided using active and problem-based learning that builds on the counselor's previous knowledge and incorporates a variety of instructional techniques (Beidas & Kendall, 2010; Couturier et al., 2014; Dolmans et al., 2005; Ghafoori & Davaie, 2012; Herschell et al., 2014; Stuart et al., 2004). Trainers should present material as modules, which should be presented over time (Borntrager et al., 2009; Chu et al., 2015) with continued practice to consolidate skills (Draganski et al., 2004; Knowland & Thomas, 2015). An internship experience is able to incorporate the required components of an effective training program (Layne et al., 2014).

A therapist's clinical experience, theoretical orientation, and attitudes toward EBTs can impact their ability to effectively implement a TF-EBT (Beidas & Kendall, 2010). An intern program provides supervised clinical experience, which can improve counselor self-efficacy and address concerns about experience (Layne et al., 2014).

Training on TF-EBTs can ameliorate any negative impact of theoretical orientation on therapist attitudes toward TF-EBTs (Allen et al., 2014; Beidas & Kendall, 2010).

Client factors such as appropriateness for an intervention, severity of symptoms, and risk factors can impact the likelihood that therapists will successfully implement a TF-EBT (Beidas & Kendall, 2010). Therefore, trainers and supervisors need to consider the impact of symptom severity on treatment outcomes and assess clients' appropriateness for treatment (Beidas & Kendall, 2010). There is limited research, however, on the impact of client variables on implementation of TF-EBTs. Some research suggests that consultation and support can improve client outcomes regardless of client variables due to improved therapist competency and higher levels of adherence (Beidas & Kendall, 2010).

Organizational issues, such as clinical supervision, consultation, and organizational support can improve implementation and success of TF-EBTs (Beidas & Kendall, 2010). Research notes that manuals and workshops alone are insufficient to produce therapist competence in TF-EBTs (Herschell et al., 2009). Consultation and supervision should also be included to improve therapist adherence and competency as well as client outcomes (Chu et al., 2015; Couturier et al., 2014; Ghafoori & Davaie, 2012; O'Byrne & Rosenberg, 1998; Schoenwald et al., 2004). Organizational support can also have a positive impact on implementation of an intervention (Couturier et al., 2014). Transformational leadership can reduce staff turnover and increase productivity, thus improving the staff's ability to benefit from dissemination efforts such as training and consultation (Green et al., 2013; Tonkin, 2013). Therefore, a training program should

include supervision, consultation, organizational support, and transformational leadership.

An intern-training program is in a unique position to implement an SC perspective to training counselors on TF-EBTs. Counselors can be trained on the core trauma competencies while receiving the experience and support they need to improve their competency. Through this program, the availability of TF-EBT services will increase for victims. Also, the training program will provide an opportunity to measure the impact of a component training program and internship model on counselor competency, as most studies examine competency after step-based training and were not using intensive training programs as found in internships. Additionally, this study would serve as a pilot study of a trauma-focused counselor competency assessment based on skills needed to implement a component treatment for complex trauma, as no such measures currently exist.

Chapter 4: Intervention

As noted in Chapter One, counselor education is a key entry point to improve the availability of trauma-focused treatment for victims of child maltreatment. Through training, counselors can improve their competency to provide TF-EBTs. As described in Chapter Three, training programs should contain a variety of components that can be applied in internships programs. To this end, the Care Clinic has an intern-training program for graduate students in psychology. The intern training program was initially implemented in Fall 2008 and consisted of informal training sessions on a variety of topics related to treating victims of trauma, supervision, and practice of skills on students' own caseloads. As previously noted (see Chapter 2), feedback from students was very positive; however, many noted a preference for a more structured treatment program to facilitate competency development. Also, the training topics were not based on any particular curriculum or treatment model. The team agreed that a treatment model should be identified and used to guide the training program. The Integrative Treatment for Complex Trauma (ITCT) model (Lanktree, & Briere, 2013) was chosen due to the evidenced support and fit for the clinical work. From Fall 2015-Spring 2016, the staff and student therapists at that time (i.e., different students/trainees than the participants of this study) reviewed the manual in weekly one-hour sessions, one component at a time. This created the basis for the intervention described in this chapter.

Method

Evaluation Questions

Did trainees display a significant increase in competency for trauma-focused treatment as indicated by scores on trauma-focused competency assessments?

How did trainees rate and describe the training components they received?

How useful was the Trauma-Focused Counseling Competency Assessment (TF-CCA) based on feedback from trainees and supervisors?

Hypothesis/Objective

After completing the intern-training program, trainees will demonstrate a significant increase in scores on trauma-focused competency assessments. The TF-CCA will provide accurate information as to trainee's skills and knowledge.

Research Design

The researcher employed mixed methods on a multi-case study. The researcher evaluated the training program and resulting counselor competency with both quantitative and qualitative data (O'Leary, 2013). Quantitative data provided concrete measurements of the gains made in knowledge and skills while the qualitative data expanded on those numbers with information about the trainees' and supervisors' experiences, specific information about their knowledge and skills, and feedback on the training program and competency assessment. Due to the small sample size, quantitative data alone would have been insufficient to evaluate the overall effectiveness of the program. Including statements from the participants helps to support and explain the results. Additionally, this combination of quantitative and qualitative data will be helpful to use when approaching funders. The quantitative data can support the effectiveness of the program whereas the qualitative data can tell the story and reach the emotional side of funders.

While randomized control trials are considered the gold standard in research due to their ability to make causal inferences and reduce many biases, they are not always the best design choice (Shadish et al., 2002; Torgerson, Torgerson, & Taylor, 2010). Shadish

et al. (2002) noted that randomized control trials are not needed if causality is already known and the focus should be on implementation. Numerous studies have shown that training programs can lead to increased knowledge and/or skills in counselors (Herschell et al., 2010); therefore, non-experiments are beneficial to get more information about implementation of comprehensive training programs. Also, random assignment is not feasible in the training program, therefore necessitating a non-experimental design (Shadish et al., 2002).

For this study, convenience sampling was used (O'Leary, 2013). Approximately 30 students from four different masters and doctoral degree programs in psychology submitted resumes and cover letters to apply for an internship at the Care Clinic. Internships are a required component of graduate education where students spend time working in agencies as counselors with supervision. Supervisors at the Care Clinic thoroughly reviewed all applications and then chose nine students to interview. Trainees were selected by the supervisors and include three masters-level students and one doctoral student. The researcher was not part of the interview and selection process. All four trainees were invited to participate in the research study, therefore using convenience sampling (O'Leary, 2013).

Due to the small sample size, a multiple-case study design was most appropriate and allowed for a more in-depth understanding of how the intervention works and to pilot the assessment measures (O'Leary, 2013). The case study was evaluative as it looked at the effects of a program (Schutt, 2014). Evaluation studies can examine different aspect of programs such as program design, implementation, and outcomes (Rossi, Lipsey, & Freeman, 2004). The present study examined the program design (i.e., the training

components and assessment measures) and outcomes (i.e., counselor competency). Both qualitative and quantitative data were used to provide a broader picture of the training program and its impact (O'Leary, 2013). The researcher compared pre-, mid-, and post-assessments of the trainees. Participants' scores were then compared to their own pre-tests to see how much their competency improved following the intervention. Therefore, the design elements included non-random assignment, a single pre-test, and repeated post-test measurements (Shadish et al., 2002). In addition, open-ended questions were included on the competency assessments and the researcher conducted semi-structured group interviews to gain the perspectives of the trainees and their supervisors on the training components and the competency assessment.

Sample

Participants were graduate students in psychology (clinical and counseling) in the Baltimore area. All four trainees were invited to participate in the research study. Three were master's degree students in their second and final year of the masters and one was a doctoral student in their fourth year of the program in which they complete 9-month internships/externships. All participants were females in their mid-to-late twenties; two were White and two were Asian. One supervisor was a White female (LCMFT) and the other was an Asian male (PsyD, licensed psychologist).

Instrumentation

For this study, there were several assessment measures used to measure program fidelity and outcomes (see Table 1). Implementation measures included activity logs, survey responses, and training logs. Outcomes measures included competency assessments and group interview results.

Implementation measures. To determine fidelity, the researcher first had to determine if all three components were provided and if training sessions included all the necessary training topics. Then, data that was collected to measure the dosage of all three components was the number of hours of each component over the course of the program. The indicators for training sessions were the number of training sessions, the content of those sessions, and trainee response. The supervision indicators were the number of supervision hours for individual and group supervision, the content of supervision, and the participants' response to supervision. Indicators for practical experience were the number of face-to-face hours spent with clients and the focus of sessions. Therefore, there were three main indicators of implementation fidelity: number of hours logged for each component, trainees' response to each component, and content of the components.

Activity logs. Trainees kept logs that were completed weekly and signed off by the supervisor. The trainees used activity logs to track the number of individual and group supervision hours, the number of hours spent in training, and the number and types of direct client-contact hours. Trainees completed the logs weekly and presented them to their supervisors to review and sign off. At the end of each semester, the students were required to total the number of hours for each component. Trainees reviewed their logs with their supervisors to ensure that they each received the required dosage of each component.

Training attendance logs. A training attendance log tracked the number of trainings, the participants for each session, and the topic for each session to determine the dosage. Attendance logs were completed at the beginning of each of the training sessions as facilitated by the evaluator. The evaluator reviewed the logs to monitor program

implementation. Between the training attendance logs and trainee activity logs, the evaluator was able to determine if each component was provided at the recommended dosage as one measure of implementation fidelity.

Training program surveys. At the end of the internship program, trainees completed self-report surveys to monitor their responsiveness to the program components. The evaluator sent the survey to the trainees and collected them upon completion for review. All surveys contained both rating scales and comment sections to get a more complete picture of the trainees' response to the training program and level of engagement.

Outcome measures. As the goal of the training program is trauma-focused counselor competency, measures are needed to assess the trainees' competency at the start and end of the program.

Trauma-focused counseling competency assessment. Participants completed a TF-CCA Self Rating Scale while their supervisors completed the TF-CCA Supervisor Rating Scale (see Appendices C & D). Supervisors were asked to rate the trainees using a Likert-scale of one to eight based on their perceptions of the trainees' mastery (i.e., knowledge and skills) of the 16 treatment components of the ITCT model. The ratings included novice (1-2), beginning/minimal competency (3-4), advanced beginner/moderate competency (5-6), and competent (7-8). Each competency was defined for the rater and a rubric was provided to provide clarification on what each rating meant. The measure also contained open-ended questions to provide qualitative responses about trainees' knowledge and skills and responses to the various components of the training program. Trainees and their supervisors completed these scales at the start

the training program, at mid-point, and at the end of the training program. See Appendices C and D to view the measure.

Interviews on experiences in the program. The researcher conducted semi-structured interviews (see Appendices E & F) in a group format with the trainees and with the supervisors at the conclusion of the training program to gather more information on their experiences in the program and the development of their knowledge and skills to treat complex trauma. They were also asked about the most helpful and least helpful aspects of the program.

Procedure

The researcher began by meeting individually with each trainee to discuss the study, including the procedures, risks, benefits, and ability to withdrawal their consent at any time. Once their consent was obtained, participants and their supervisors were also given the TF-CCA Self and Supervisor Rating Scales to serve as a baseline.

The treatment consisted of participation in the trauma-focused internship program, which included multiple components: Training sessions, supervision, observation, and practice with feedback. Trainees received trainings on Trauma-Focused Evidenced-Based Treatments (TF-EBTs) and core trauma competencies using strategies from the learning sciences (Beidas & Kendall, 2010; Layne et al., 2014). See Table 2 for a timeline outline of key activities. Trainings occurred in the first semester beginning with orientation (four days over a two-week period) and continued weekly (60-minute sessions) for the first 15 weeks. During orientation, trainees participated in information sessions on policies and procedures, attended clinical training and team meetings, and observed sessions of other therapists via a two-way mirror or sitting in the room during

sessions. Trainees observed experienced counselors to improve their learning of the relevant skills and to help them acclimate to the role of counselor (Couturier et al., 2014; Ghafoori & Davaie, 2012).

Training sessions included trauma competencies for treating children and their families using the ITCT model (Lanktree & Briere, 2013). Weekly training sessions during the first semester covered the ITCT model with one 60-minute session for each of the following components: understanding complex trauma, assessment, advocacy, therapeutic relationship, safety, affect regulation, identity development, psychoeducation, cognitive and emotional processing, relational processing, behavior self-control, interventions with caregivers, family therapy, and self-care (Lanktree & Briere, 2013).

Trainees received weekly group and individual supervision to provide support and feedback to trainees (Couturier et al., 2014; Ghafoori & Davaie, 2012; O'Byrne & Rosenberg, 1998). Supervision began during the first week of the internship and continued weekly throughout the placement. Students received one hour of individual and one hour of group supervision per week using a reflective supervision model (Heller & Gilkerson, 2009). Individual supervision was provided by either a licensed clinical psychologist or a licensed marriage and family therapist. During individual supervision, supervisors provided feedback to trainees on their skills based on case discussion, observation of sessions, and review of clinical notes and reports. Group supervision was conducted during multidisciplinary team meetings in which the team discussed cases and provided feedback. The team meetings were led by the researcher, who is the program director and a licensed clinical professional counselor, and included the students, a psychiatrist, psychologist, marriage and family therapist, consultant on mental health for

young children, and a community outreach worker. Students also received ongoing consultation as-needed from their supervisor and the team (i.e., psychiatrist, psychologist, marriage and family therapist, licensed clinical professional counselor, consultant, and pediatrician).

Each trainee had six to eight cases in order to practice their trauma-focused skills. A case is an individual client for whom the counselor provides individual and/or family therapy and advocacy. Each client was typically seen once per week and sessions focused on addressing treatment priority areas using treatment components as indicated by the ITCT model (Lanktree & Briere, 2013). For example, a counselor may teach coping skills to address affect regulation and facilitate completion of a trauma narrative to alleviate symptoms of posttraumatic stress. Trainees were advised to record all sessions for which they had secured permission. Trainees were responsible for charting all contacts and completing clinical documentation for their clients (i.e., evaluations, treatment planning, treatment updates, and discharge summaries). Trainees then discussed cases in individual and group supervision to obtain feedback to improve their skills. They also provided session recordings and clinical documents to their supervisors for review.

Trainees and supervisors were again given the TF-CCA Self and Supervisor Rating Scales at the mid-point of the internship (January, 2017) and at the end of internship (May, 2017). The researcher additionally met with the trainees and the supervisors for 60-minute semi-structured interviews at the end of the internship.

Data collection. Both quantitative and qualitative data was collected. The TF-CCA Self and Supervisor Rating Scales were scored by adding up total scores of the ratings. Qualitative data was collected through open-ended questions on the scales and

semi-structured interviews with the participants and the supervisors facilitated by the researcher. Notes from these interviews were typed and then sent to the participants for individual verification.

Data analysis. Quantitative data was analyzed using descriptive statistics to include range of scores on measures, average scores, changes in scores throughout the program, and differences between the average rating of supervisors and trainees. The researcher determined a composite score for each trainee combining the scores from the self-rating scale and supervision rating scale. The researcher compared each trainees' scores and total scores from pre-, mid-, and post-interventions within the treatment group using a one-tailed *t*-test. Open-ended responses on the measures and interview transcriptions were analyzed.

Chapter 5: Findings

Results

Research Question 1

The first research question asked, "Did trainees display a significant increase in competency for trauma-focused treatment as indicated by scores on trauma-focused competency assessments?" To answer this, the trainees and supervisors were administered the TF-CCA pre-, mid-, and post-training and qualitative feedback was obtained via opened-ended questions on the assessment measure and in semi-structured interviews. Two trends were evident in the results of the assessment measure as shown in Tables 3 and 4 as well as Figures 1 and 2. First, scores increased from pre- to post-assessment, with the greatest increase between pre- and mid-assessment, reflecting an increase in counselor competency. Secondly, the trainees' self-rating scores were higher than the supervisors' scores, indicating that trainees tended to rate themselves as more competent than their supervisors had rated them (see Figure 2).

Composite Scores were determined by adding up the self-rating and supervisor scores for each administration for each subject and are shown in Table 3. The composite scores at pre-assessment ranged from 95 to 141 with an average of 122.25, while the range at post-assessment was 148 to 174 with an average of 158.5. The composite scores increased by 36.25 points from pre- to post-test (see Figure 1). Although this increase was statistically insignificant ($t(3) = 2.344$, p = n.s.), the students went from the category of beginning/minimal competency to advanced beginner/moderate competency. It should be noted, however, that the scores increased the most from pre- to mid-assessment by

41.875 points, which was statistically significant ($t(3) = 3.889$, $p<.05$) and then dropped slightly at post-assessment.

Although self-report and supervisor scores followed the same pattern of a statistically significant increase at mid-point and a slight decrease at post-assessment, they differed in the amount of change and the competency level (see Figure 2). At the pre-test, the average score of the self-report was 66.75 and supervisors' score average was 55.5 (see Table 4). Therefore, students were rated in the beginning/minimal competency level based on both self and supervisor report, although on the lower end of the range based on supervisor reports. At post-test, however, a difference emerged as the average scores were 94.25 and 64.25 for self and supervisor respectively. Self-ratings increased to advanced beginner/moderate level competency while supervisor ratings placed the trainees lower on the high end of beginning/minimal competency category. While there was a 27.5 point increase for self-reports, there was only an 8.75 point increase for supervisor reports. As noted, however, the average scores for both the trainees and the supervisors were higher at mid-points (95.875 and 68.25 respectively) compared to post-test, therefore the results of the self-reports and the supervisor reports followed the same pattern.

Qualitative data also suggested an increase in competency throughout the training program. Both the trainees and the supervisors reported an increase in knowledge and skills. One trainee said, "I learned so much information" while another explained that initially "I felt really insecure, but now I feel a lot more comfortable." The trainees noted that they were able to develop their own styles while learning the needed skills. They used terms such as "genuineness" and "comfort" regarding their growth. The supervisors

confirmed this growth citing “improved knowledge” and “better at recognizing and implementing skills.”

Research Question 2

The second research question explored how trainees rated and described the various training components they received. Trainees and their supervisors were asked for feedback on each of the training components through the TF-CCA and the group interviews.

Reading the manual. Overall, it appeared that reading the manual was helpful for the students and the supervisors; however, the students reported that they only read approximately 65-70% of the manual. They provided specific feedback on the format of the manual (e.g., the binder with all of the components was too overwhelming) and suggested that future trainees be given the materials one component at a time. One student stated that it was helpful to have access to the manuals online to not only read it, but to be able to search for items more easily.

The supervisors seemed to find the manual especially useful for laying the groundwork of the training and treatment program without rigidly dictating what the trainees should do. One stated that the manual “separated out different domains that they [trainees] need to focus on.” The manual also helped guide supervision as it “offered a nice framework” from which supervisors can coordinate and tailor supervision to address the various components. They noted that it would be helpful for supervisors to be alerted to which components are covered when so that they can follow up in supervision.

Didactic training sessions. The feedback from both the trainees and supervisors on the training sessions was very positive, especially for increasing knowledge. One

trainee wrote “The trainings made me very knowledgeable about the nature of complex trauma and components of ITCT treatment.” They noted that they enjoyed the experiential activities and seeing examples of clinical activities (e.g., trauma narratives). The supervisors expressed that the training sessions gave the students a good “foundation” and they were a “stepping stone” for the students to begin their clinical practice. The trainees recommended that handouts (e.g., PowerPoint slides) be provided for all training sessions, that the other staff therapists also lead some of the training sessions based on their expertise, and that more hands-on activities would be helpful. One trainee also noted that the sessions were too spread out and they would have preferred them chunked sooner in the placement.

Supervision. While the trainees provided some specific examples of what they liked about their supervisors (e.g., quick response time, support, and flexibility) they also noted many benefits to the process of supervision and related growth. A trainee wrote that “this is a useful component as supervisor is able to suggest not only different ways of responding to issues, but also help to identify blockages or overlooked issues.” The trainees noted learning essential clinical skills in supervision. The trainees described not only clinical benefits, but also personal ones. One supervisee stated that “the supervisor believing in me made me believe in myself.” Another trainee noted that the supervisor helped them “to connect personal stuff to clinical work” and address countertransference. Other positive comments included “I learned more about myself,” “I gained empathy for my clients,” and I received “invaluable guidance.” One trainee added that the group supervision was “invaluable because of the multiple perspectives.”

Supervision was reported to be one of the main avenues that a supervisor has to evaluate trainees while serving as a platform to teach skills and support trainees' growth and reflection. One supervisor described supervision as "vital" and noted that "I feel like I'm a point person for her", the "catchall," "the one who helps pull it all together." Another supervisor noted that observing behind the one-way mirror was the most useful supervision tool and was better than watching tapes (recorded sessions). They agreed that holding regular supervisors' meetings (i.e., monthly) would be helpful to gain support on supervision, promote some consistency in supervision practices, and exchange supervision ideas.

Observation of other therapists. The trainees appreciated the opportunity to observe other therapists, especially early on in the training program. One wrote that it was "very helpful to watch another clinician go through a trauma narrative and handle crises in the sessions" and "to see various theoretical orientations influence trauma work." Another trainee wrote, "This will provide trainee with different styles of working with trauma clients, in addition to exposing trainee to clients' diversities." Another commented that it was "helpful to see therapy in action." The students noted that observation was key to see how to use specific interventions and engage clients although they wished they had done more of it, especially in the beginning. One trainee suggested that they would like the staff therapists to invite students to observe if they know that they will be using a specific technique that they would like the students to learn.

The supervisors also spoke positively about observation. One stated that it was "very helpful [for trainees] to see different therapists and styles". Another stated that observations are a "good starting point" especially when trainees have not built up their

caseloads yet. One supervisor wrote that the trainee "gains a lot from direct observations of role models."

Practice with feedback. The trainees suggested that this was one of the most important parts of the training program. They described a process of the work getting easier and they became more efficient and comfortable. On trainee stated, "Before I felt drained, now it doesn't take as much energy" while another noted improvement with writing session notes, "in the beginning, I wrote everything down…now shorter." A trainee wrote, "practicing has built my confidence as a clinician" which was a sentiment that was shared by all. Another trainee expressed that through practice, the skills "are now automatic."

The supervisors stated that the practice was "very helpful" and that the learn-see-do model seems to work well. They noted how the trainees' skills were applied in session and areas of strengths and weaknesses were explored. One supervisor highlighted the importance of the practice to assess the trainees' skills.

Organizational factors. The trainees also provided some feedback on the internship as a whole. The benefits of the program seem to relate to a supportive environment. Their comments included that they liked the "freedom to do different things" and "allowed to be as independent as we wanted to be," and "got to be creative in the job and come up with new things." They noted growth compared to other students in their graduate program such as being able to "take different perspectives," and "think more critically" compared to interns in other sites. They seemed to appreciate being part of the team. "Our opinion was incorporated." They noted feeling like "part of the team" and "valued."

Research Question 3

The last research question examined the usefulness of the TF-CCA based on feedback from trainees and supervisors. Overall the feedback was positive even though the results showed some questionable trends. First, the scores decreased slightly from mid- to post-assessment (see Tables 3 & 4) even though student and supervisor reports noted ongoing growth. Secondly, there was no positive correlation between self and supervisor ratings. There was a weak/no correlation between the self and supervisor scores at the pre-test (r = -.05). At both mid- and post-test, there was a moderate correlation (r = -.59 and -.60 respectively), but it was indirect. Therefore, the students giving themselves the higher scores were given the lower scores by the supervisors and vice versa (See Tables 5).

The trainees noted that it was "comprehensive," "touched on a lot of things," "there was nothing else that could have been included that would have been relevant," and that the rubric with the behavioral descriptions was helpful. The trainees expressed that it was hard to complete the scale the first time without context and they did not know what some of the concepts meant. One supervisor felt that knowledge and skills should be separate questions. When the interviewer asked if trainees should be given guidance on expectations (e.g., that the highest scores are not expected), the trainees indicated that trainees could benefit from some guidance, including that supervisors are not expecting proficiency.

The supervisors did not review their ratings with the trainees, and neither the trainees nor the supervisors felt comfortable with the idea of reviewing the scale and results together. A trainee stated that reviewing the results "could be helpful, but not my

favorite" which seemed to accurately reflect the group's overall sentiments. They noted that trainees could get more information on how to get better and the supervisors could then explain what everything meant, but that knowing the supervisor's expectations might cause anxiety for the students and skew later self-ratings. One supervisor stated that "I probably wouldn't review it with them, but I'm not sure why not" while they noted that "I could see the value of talking about it in general" and could use it as a tool. The reluctance to share the results may be due to their perception that the scale's purpose was to measure the effectiveness of the training program, not as a tool to help clinicians monitor and develop their skills for treating complex trauma.

Discussion

The study used a multi-case study to pilot an intern-training program and trauma-focused counselor competency assessment measure. The focus was to evaluate the intern-training program by examining changes in trainees' trauma-focused competencies and the importance of the various training components. As a competency assessment measure, the TF-CCA was created for this study and its usefulness was also evaluated. The results can then be applied to future training programs or research studies.

Research Questions

Effectiveness.

To determine the effectiveness of the training program, the researcher used quantitative data from the TF-CCA and qualitative data from open-ended questions on the TF-CCA and through group interviews. The results of the TF-CCA were indicative of significant increases in trainees' competency from pre-test to mid-test, but not from pre-test to post-test. Although there was an increase in scores from pre- to post- (the students

went from the category of beginning/minimal competency to advanced beginner/moderate competency), it was not clinically significant, therefore may not be related to participation in the training program. This contradicts the comments from both the trainees and supervisors that noted significant improvement in competencies throughout the program, which they attributed to the program. The lack of statistical significance from pre- to post- could be due to the small sample size. With a small sample size, there is low statistical power, which makes it harder to detect significant results even when they occur (Shadish et al., 2002). Also, as the TF-CCA has not yet been validated, the discrepancy could be related to the assessment tool. During the internship-training program, trainees did improve in their knowledge and skills related to treating complex trauma based on comments by the trainees and their supervisors. While the nature of this study prohibits assumptions that the increase was due to the training program, the feedback from both trainees and supervisors suggests that the training program was likely a very important contributor to trainees' growth.

Training Components.

A second area for exploration was the training components. The training program was based on the SC perspective, which states that training, therapist, client, and organizational factors should all be addressed to increase therapist adherence to evidenced-based treatment models and improve client outcomes (Beidas & Kendall, 2010). To address all four factors, the program included several components: didactic training sessions, reading the manual, supervision, observation, and practice with feedback. Training factors were improved by implementing training techniques and formats based on the learning sciences and dissemination research (Beidas & Kendall,

2010; Couturier et al., 2014; Dolmans et al., 2005; Ghafoori & Davaie, 2012; Herschell et al., 2014; Stuart et al., 2004). Therapist factors were addressed through training on TF-EBTs and supervision which can mediate the effects of therapist experience, attitudes toward EBTs, and theoretical orientation to improve implementation of TF-EBT (Allen et al., 2014; Beidas & Kendall, 2010; Layne et al., 2014). Client factors were attended to through supervision as supervisors helped trainees to determine when and how to adapt the treatment model to each client and by improving therapist competency and adherence (Beidas & Kendall, 2010). Organizational factors, such as clinical supervision, consultation, and organizational support can improve implementation and success of TF-EBTs (Beidas & Kendall, 2010). Organizational factors were improved through the use of transformational leadership that was incorporated in supervision (group and individual) and the training sessions (Green et al., 2013; Tonkin, 2013).

Even though trainees were not asked about all four factors of the SC perspective, their feedback on the training components supported the importance of each of factor. Although they noted that reading the manual was helpful, the results suggest that, as Herschell and colleagues (2009) found, it was not enough. Not only did the trainees not read the full manual, participants highlighted the importance of other training components to improve training factors. In fact, they indicated that all of the components were crucial. Trainees noted that they enjoyed the hands on activities in the training sessions, which were crucial to learning the skills. The supervisors emphasized the importance of the training sessions to lay the groundwork for trainees' skills and knowledge. Both the trainees and supervisors stressed the importance of supervision to address client factors and implementing the treatment model. Also, trainees spoke about

the support, encouragement, and empowerment they received from the organization, thus highlighting the importance of the organizational factors. Overall, the feedback from trainees and the supervisors on the training program was very positive. Both the trainees and the supervisors noted increased competency to provided treatment for complex trauma and related this growth to all of the components of the training program.

TF-CCA.

While the increase in competency was supported via the results for the TF-CCA, there were some issues. First, ratings placed new students in the beginning/minimal competency instead of novice category even though they had not provided trauma treatment prior or received specific training. This may be because they learned some of the related knowledge in prior graduate coursework; however, it is unlikely that they knew about each of the components or that the material was presented through a trauma framework. Additionally, trainees completed the measures after being on-site for two weeks; therefore, they may have already benefited from training sessions. Without a pre-test of knowledge, it is unclear if students really did possess the knowledge of beginning/minimal competency or if the respondents were inflating the scores.

Second, it is interesting that scores improved from pre- to mid-assessment and then reduced slightly at post-assessment. It is unlikely that students' knowledge and skills reduced, especially since both trainees and their supervisors reported improvement. There are several possible reasons for the decrease in scores from mid- to post-assessment. One possibility is the time lapse between the didactic training sessions and the assessments. The mid-assessment occurred less than four weeks after the last training session whereas the post-assessment occurred almost four months after the last session.

There could be an error with the measure itself or with how the user completed the measure. The reporters' expectations may have increased, therefore reducing scores even though the trainees demonstrated improvement. Another possibility is that as the difficulty of the work increased, trainees' self-efficacy and their supervisors' perceptions of their skills decreased slightly.

Third, the trainees rated themselves higher than the supervisors rated them. This matches the results of Swank's (2014) study that found that students rated themselves significantly higher than their supervisors and faculty. The reasons behind the differences between the trainees' and supervisors' responses are unclear and there is no research to explain it. Also, other studies have found contradictory results. While Swank (2014) found that supervisees rated themselves higher than their supervisors, McManus et al., (2015) found the opposite. In the present study, there was no direct correlation between the trainees' self-reports and the supervisors' reports. Overall, with such a small sample size it is hard to determine how well the TF-CCA can detect changes in competency and if the difference between trainees' and supervisors' scores would exist with larger samples. Regardless of its ability to evaluate the effectiveness of the training program, the TF-CCA appears to be a useful tool for clinicians and/or their supervisors to monitor clinicians' trauma-focused skills and development.

Recommendations

As this study functioned as a program evaluation of a training program, the results identified areas to improve in future training cohorts. In the future, each training session will be formalized with identified learning objectives and handouts (e.g., presentation slides and resource sheets). More training sessions should occur during orientation (four

sessions) and then spread out the rest over the first semester (one per week for weeks 3-15) in order to give the trainees a better base prior to seeing their own clients. Students will be given the manual electronically at the onset of the placement so that they can begin to read it prior to starting the placement. To reduce feelings of being overwhelmed, each trainee will build their own training manual with resources as they progress through the program. While the study examined each of the components of the training program (training sessions, supervision, observation, and practice with feedback), it did not evaluate the effectiveness of each didactic session. Therefore, future training sessions will include evaluations given at each session to determine areas to improve for that specific session. Training sessions will be provided by different members of the clinical team based on their areas of expertise. Presenters/team members will review each of the session outlines for their feedback. To ensure high quality, the researcher will provide a training session for all presenters on teaching for adult learners. Supervisors will meet monthly for collaboration and peer support and to improve consistency in supervision methods. Supervisors will be informed of the training schedule so that they can follow-up on didactic training sessions in supervision. Lastly, revisions will be made to the assessment process such as training for users or clearer directions for the trainees and the supervisors. With these revisions, the training program can be improved and re-evaluated in an on-going process to provide the best training experience possible so that more counselors can be equipped to provide evidenced-based treatment to victims of child maltreatment.

Future research should continue to examine the impact of internships on trauma-focused counselor competency using larger sample sizes and doing additional post-tests

in a one-year follow-up to see if gains can be maintained. Studies are needed to validate a comprehensive measure of trauma-focused competency employing component-based models of treatment such as the ITCT model. The TF-CCA needs to be tested with more trainees and supervisors to determine its usefulness for measuring competency to treat complex trauma or as a supervisory tool to monitor their growth of trauma-focused skills. Additionally, a pre- and post-test for knowledge could be offered for a more objective measure of knowledge. Future studies could compare the results of a knowledge test to the results of the TF-CCA. Additionally, it is recommended that more than one supervisor rate each student after observing session tapes and reading reports to examine inter-rater reliability.

Strengths and Limitations

The research shows that common dissemination methods may not lead to counselor competency in evidenced-based trauma treatments (Allen et al., 2012; Herschell et al., 2009). One model, the intern training program, has been suggested as an alternative due to the ability to include multiple components to increase competency and fidelity to the treatment model (Layne et al., 2014). There are several issues with the current body of research on training counselors to treat trauma. First, many studies focused on manualized treatments even though counselors prefer modular treatments and are more likely to stick to them (Borntrager et al., 2009; Chu et al., 2015). Second, the studies did not focus on training counselors to treat complex trauma, which may include more comprehensive and complex models compared to simpler traumas (Lanktree & Briere, 2013). Also, the dissemination methods studies did not compare internship-training programs to dissemination models. Lastly, studies used different methods to

determine the outcomes of their training programs (e.g., tests of knowledge, self-reports of skill usage, and therapist following of treatment manuals). Some used supervisor or trainer reports, while others used self-reports. Few have examined knowledge and skills usage, especially for treating complex trauma using modular treatments. The present study attempted to address gaps in the research through a case study examining a pilot of an internship training program that focuses on treating complex trauma through a modular treatment (ITCT) and using a trauma-focused assessment tool to measure counselor competency incorporating both supervisor and self-reports.

There are several advantages to this case study design. The case study allows for a more in-depth analysis of the program and its impact and the mixed methods provided a more complete picture of the results and process (Martinson & O'Brien 2010; O'Leary, 2012). Martinson and O'Brien (2010) explain that another advantage of case studies is their ability to explain the process through which (i.e., how and why) interventions/programs obtain thier outcomes. Also, the study provided an opportunity to pilot the assessment measures as they were created for this study. Once the assessment measures have been piloted, then future studies could be devoted to validating the measures and intern-training program. The use of a pre-test and post-test also establishes temporal precedence (Shadish, 2002). As with other non-experimental designs, another advantage of the case study is that the conditions are real-life and can therefore offer a more realistic understanding of an intervention than a randomized control trial (Shadish et al., 2002). As mixed methods were used, the researcher had the benefit of both qualitative and quantitative data to more fully evaluate the training program and resulting counselor competency (O'Leary, 2013). Quantitative data provided concrete

measurements of the gains made in knowledge and skills, while qualitative data expanded on the numbers with information about the trainees' and supervisors' experiences and specific information about their knowledge and skills.

There are several limitations for this study. Most importantly, case studies do not yield generalizable findings (Martinson & O'Brien, 2010). Also, as nonrandom sampling was used, no causal statements can be made (Shadish et al., 2002; Torgerson et al., 2010). There are several threats to statistical conclusion validity such as low statistical power and unreliability of treatment implementation (Shadish et al., 2002). Given the small sample size, there is low statistical power, which makes it harder to detect significant results even when they occur (Shadish et al., 2002). One component of the intervention is supervision of the trainees. Supervision was provided by two different supervisors, which can lead to differences in implementation and therefore can affect the results.

Internal validity threats are also present. As there was no comparison group, there was no way to rule out maturation, selection, testing, and history biases (Henry, 2010). Selection bias is likely, therefore the results may be due to some other characteristic of the participants other than receiving the intervention (Henry, 2010; Shadish et al., 2002). Instrumentation is also an issue as there were no known valid instruments to assess for trauma-treatment competencies (knowledge and skills) of a comprehensive, component treatment model. The measure was reviewed by other experts in treatment of complex trauma to establish face validity; however, more extensive testing of the measures are needed.

Despite the limitations, a case study was chosen as this is an exploratory study to evaluate an intern-training program and to pilot test a new trauma-focused competency

assessment measure. Also, randomization was not possible in the setting. Pre- and post-tests were added to reduce threats to validity; however, the results are not generalizable. Regardless, the pilot program provides a good base for future research on training counselors to treat complex trauma using an evidenced-based component model and for an assessment tool to measure their competency. From this study, the researcher was able to create a training curriculum that encompasses all of the components needed for treating complex trauma. The curriculum includes an outline with presentations and handouts. The curriculum could be used for internship, post doctorate, or continuing education training programs or as a graduate course. The research also confirmed other studies that showed that training programs should include a variety of components such as didactic sessions, supervision, and practice with feedback. From here, future studies can evaluate if such comprehensive training programs result in counselor competency and fidelity to evidenced-based treatment for complex trauma.

Additionally, the TF-CCA that was created for this study may serve as a useful tool, once validated, to not only evaluate training programs, but also for counselors at any level to monitor their progress towards competency to treat complex trauma. As most of the dissemination studies on treating trauma focused on manualized treatment models, there were no tools found in the literature that could be used to study component treatment models and that examined both knowledge and skills. The TC-CCA is new in that it can be used for component treatment models, includes knowledge and skills, and addresses the treatment needs for complex trauma. Those strengths can also be applicable if the tool is used for professional development. Counselors can use the tool themselves or with their supervisors to see what knowledge and skills they need and to reflect on

their progress. This could also help supervisors to more accurately determine areas to focus on in supervision if there are noticeable gaps in some of the competencies.

Conclusion

Child maltreatment is a rampant and costly problem that effects victims in numerous devastating ways (Fang, Brown, Florence, & Mercy, 2012; USDHHS, 2017). While there are cost-effective treatments, most counselors are not using them, leaving many victims without the appropriate intervention (Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013; Gospodarevskaya & Segal, 2012). Of all of the factors that impact the availability of TF-EBTs, counselor education is the most actionable. Researchers argue that a lack of training on TF-EBTs is a key factor in the limited supply of effective interventions for victims of maltreatment (Allen & Johnson, 2012; Borntrager, Chorpita, Higa-McMillan, Daleiden, & Starace, 2013; Driscoll et al., 2003; Hanson et al., 2013; Kolko, Cohen, Mannarino, Baumann, & Knudsen, 2009; Nyman, Nafziger, & Smith, 2010; Sigel, Benton, Lynch, & Kramer, 2013). This suggests that interventions should target counselor education through training programs, such as an internship program (Layne et al., 2014). An SC perspective asserts that addressing training, therapist, client, and organizational factors can result in improved therapist adherence and client outcomes (Beidas & Kendall, 2010). This can be done via a trauma-focused internship-training program that contains multiple components and provides intensive training and experience (Beidas & Kendall, 2010). Through a multi-case study, the researcher was able to pilot an intern-training program and a trauma-focused counselor competency assessment measure.

The treatment consisted of participation in the trauma-focused internship program, which included multiple components: training sessions, supervision, observation, and practice with feedback. Trainees received trainings on TF-EBTs using strategies from the learning sciences (Beidas & Kendall, 2010; Layne et al., 2014). Students were trained using the ITCT model. Trainees and supervisors were given the TF-CCA Self and Supervisor scales at the beginning, mid and at the end of internship to assess for changes in their competency. Also, the researcher met with the trainees and the supervisors for semi-structured interviews at the end of the internship. Trainee and supervisor feedback was very positive for both the training program and the assessment measure.

Results from the assessment measure showed that trainees demonstrated significant improvement in their competencies from pre- to mid-assessment. The scores then decreased slightly at the final assessment despite reports that competency improved. The decreased scores may relate to increasing expectations, although with such a small sample size the validity of the measure cannot be determined. Through the study, a treatment curriculum and assessment measure were created and piloted. The pilot program provides a good base for future research on training counselors to treat complex trauma using an evidenced-based component model and for an assessment tool to measure their competency. From here, further research can be done to validate the measure and to determine if the training program is effective at increasing competency with a larger sample size and if the competencies would be maintained at follow-up. Also the training curriculum could be applied to a variety of formats to teach counselors and other clinicians the competencies that are needed to treat complex trauma. By training

more counselors to provide TF-EBTs, more victims can have access to high quality services to help them heal.

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Table 1

Data Collection Instruments

Instrument	Indicator	Data Collection Tool	Frequency	Responsibility
Activity Log	Implementation - dose	log	At each training Weekly	Researcher Trainee
Training Attendance Log	Implementation - dose	log	At each training	Researcher
Training Program Surveys	Implementation - participant responsiveness	Self-report Surveys	At the end of each training session and post-internship	Researcher
Trauma-Focused Competency Assessment –	Outcome – Knowledge and skills for trauma treatment	Self & Supervisor rating	Pre, mid, and post-internship	Researcher

Trainees and Supervisor Group Interviews	Outcome – participant response	Structured interviews	post-internship	Researcher

Table 2

Timeline

Date	Task	Description	Person Responsible
8/29/16-9/2/16	Trauma-Focused Counselor Competency Assessment	Pre-test of competencies	Trainees and supervisors
8/29/16-9/9/16	Orientation	Orient trainees to program and begin training sessions, supervision, and observation	All clinical staff
9/12/16-12/20/16	Training sessions	Weekly 60-min sessions on core trauma-focused treatment components	Researcher
9/12/16-12/20/16	Training Attendance Log and Surveys	Log to track attendance and topic for each training session.	Researcher
9/12/16-12/20/16	Training Surveys	Survey to provide feedback on session contact and training methods after each training session.	Trainees
9/12/16-4/28/17	Supervision	Weekly 60-min individual and group supervision	Supervisors and Researcher

		sessions on trauma-focused treatment	
9/12/16-4/28/16	Practice	Provide trauma-focused counseling for a caseload of 6-8 clients	Trainees
12/20/16	Activity log	Trainees submit log	Trainees
1/9/1-1/13/17	Trauma-Focused Counselor Competency Assessment	Mid-test of competencies	Trainees and supervisors
4/24/16-4/28/16	Activity log	Trainees submit log	Trainees
4/24/16-4/28/16	Trauma-Focused Counselor Competency Assessment	Post-test of competencies	Trainees and supervisors
	Interviews	Semi-structured interview with trainee group and supervisor group	Researcher
5/1/17-5/5/17	Training Surveys	Survey to provide feedback on training program components	Trainees

Table 3

Descriptive Statistics of Scores

Composite Scores	**N**	**Range**	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Pre-test	4	46.00	95.00	141.00	122.2500	20.35313
Mid-test	4	15.00	156.00	171.00	164.1250	6.25000
Post-test	4	26.00	148.00	174.00	158.5000	11.12055
Self-Report	**N**	**Range**	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Pre-test	4	40.00	43.00	83.00	66.75	17.01715
Mid-test	4	16.00	89.00	105.00	96	6.68331
Post-test	4	30.00	80.00	110.00	94.25	12.60622
Supervisor Report	**N**	**Range**	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Pre-test	4	27	46	73	55.5	11.95826
Mid-test	4	16	59	75	68.25	6.99405
Post-test	4	7	61	68	64.25	2.87228

Table 4

Descriptive Statistics of Mean Scores:

Scores:	**Pre**	**Mid**	**Post**
Self-Report	66.75	95.875	94.25
Supervisor Report	55.5	68.25	64.25
Difference	11.25	27.625	30
Changes in Scores:	**Pre-Mid**	**Mid-Post**	**Pre-Post**
Self-Report	29.125	-1.625	27.5
Supervisor Report	12.75	-4	8.75
Difference	16.375	2.375	18.75
Composite Scores			
Averages	**Pre**	**Mid**	**Post**
	122.25	**164.125**	**158.5**

Table 5

Correlations between Self-Report and Supervisor Scores:

Scores:	**Pearson Correlation**	**Sig (2-tailed)**	**N**
Pre-Test	-0.045	0.955	4
Mid-Test	-0.585	0.415	4
Post-Test	-0.601	0.399	4

* Correlation is significant at the 0.05 level (2-tailed).

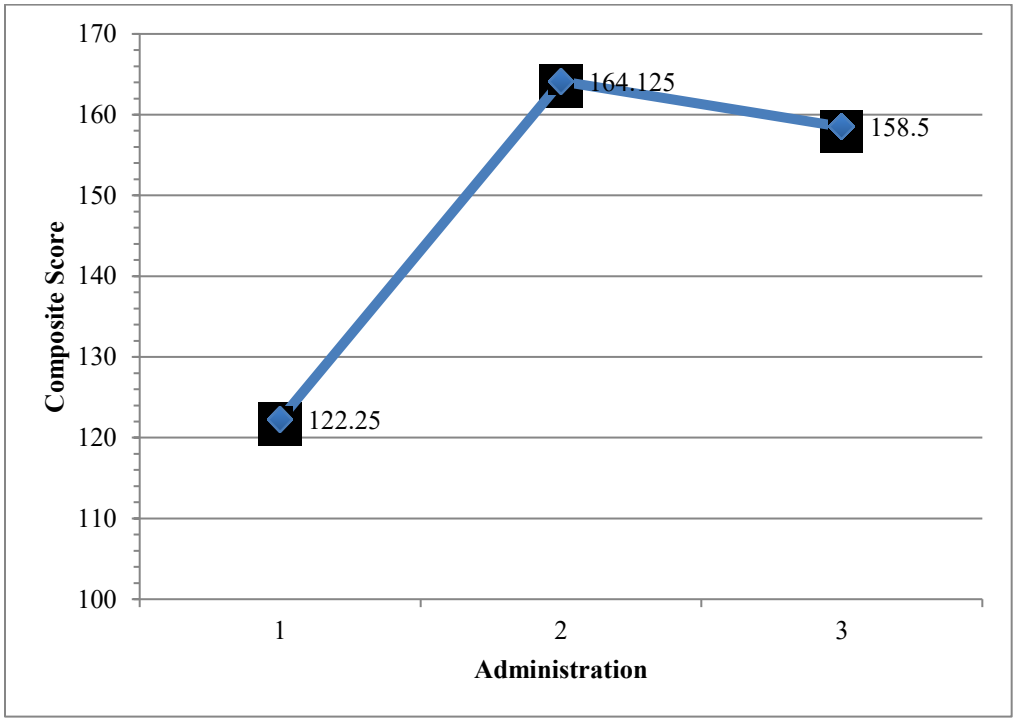


Figure 1: This graph shows the composite scores from the TF-CCA at pre, mid, and post assessment.

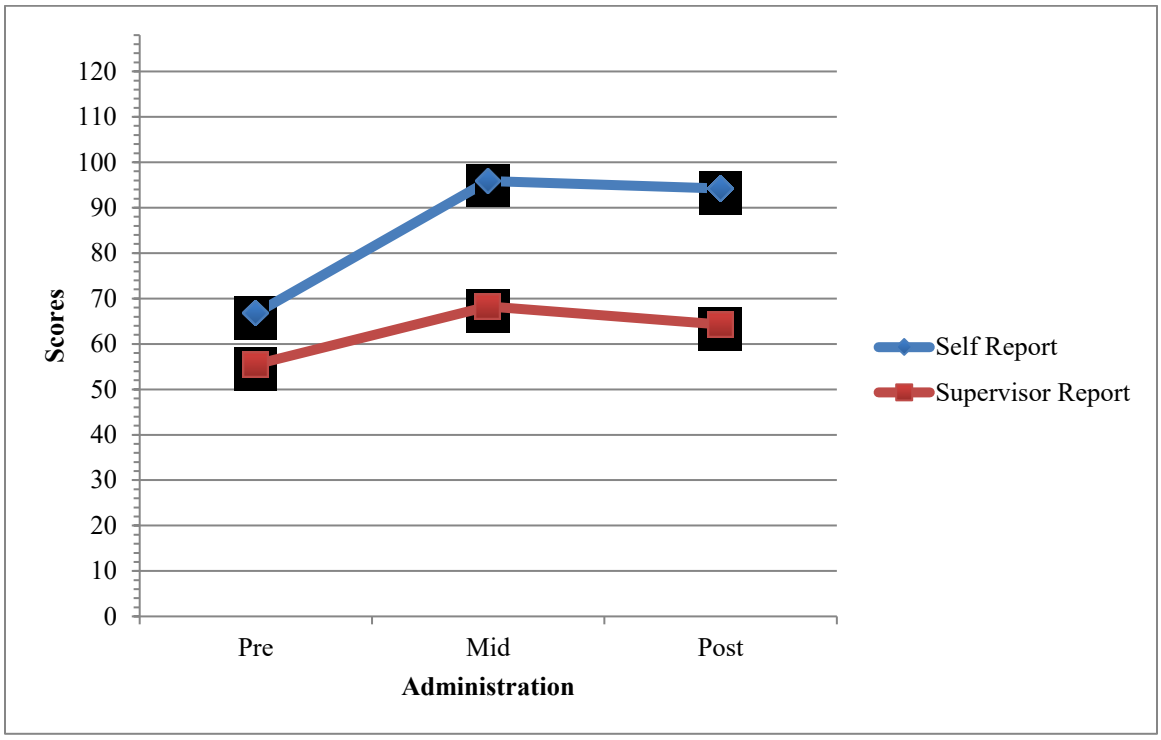


Figure 2: This graph shows both the self-report and the supervisor scores from the TF-CCA at pre, mid, and post assessment.

Evaluation of Education Programs and Policies
Recruitment and Retention Template

Recruitment and Participants:
Answer the following questions. Be succinct and clear in your responses. If a question does not apply to your intervention/evaluation please state.

1.0 Who will recruit participants for this study?

Check all that apply.

X **PI**
X **Study Team Member(s)**
☐ **No recruitment (Data analysis of existing data ONLY)**
☐ **Other**

2.0 Will you be specifically recruiting ANY of the following populations?

Check all that apply.

☐ **Children (individuals under 18 years of age)**
X **JHU Students (all at least 18 years old. If you are unsure if all students will be 18, please select 'Children' as well)**
☐ **Johns Hopkins Employees**
☐ **Non-English Speakers**
☐ **Emancipated Minors**
☐ **Wards of the State**
☐ **Cognitively Impaired/Impaired Decision Making Capacity**
☐ **Pregnant Women**
☐ **Critically Ill or Injured Patients**
☐ **Prisoners**
☐ **Homeless or Economically Disadvantaged**
☐ **None**

3.0 Choose one of the following that applies to your research as it relates to children if you selected Children above in #2.0.

☐ **The research presents no greater than minimal risk.**

☐ **The research presents greater than minimal risk but presents the prospect of direct benefit to the individual participants.**

☐ **The research presents greater than minimal risk and no prospect of direct benefit to the individual participants, but likely to yield generalizable knowledge about the participant's disorder or condition.**

4.0 Sex of participants

X **Male**
X **Female**

5.0 Describe your participant population and how you will recruit them for the study.

Participants are graduate students in clinical or counseling psychology in the Baltimore metropolitan area who are completing an internship/externship at the Care Clinic: UMB.

6.0 Provide the maximum number of participants to be enrolled.

Three

6.1 Provide justification for recruiting the above number of participants.

The intern/extern program is only able to take three students per academic year to ensure that they are able to meet their university requirement for internships/externships. Also, the case study's purpose is to pilot an assessment measure, therefore only a few participants are needed.

7.0 Describe measures that will be implemented to avoid participant coercion or undue influence.

Participants are informed that their participation is voluntary and they are given an informed consent. They are informed of their rights and are provided the IRB contact information if they have any concerns.

8.0 List the criteria participants must meet to be <u>included</u> in the study. Please describe how you will verify that participants meet this criteria and how this will be documented in your study files.

Participants of the intervention must be selected for the internship program. This means that they must be currently enrolled in a graduate program in clinical or counseling psychology in the Baltimore metropolitan area. They

will be entering their second and final year of the program in the fall 2016. Students will need to display an interest working with children or families as indicated on their cover letter and interview to be selected for the internship program and must commit to 16-20 hours a week over two-semesters to complete in the entire training program (training sessions, supervision, and practice).

9.0 List the criteria for excluding individuals from the study.

None other than not meeting inclusion criteria.

10.0 If the participant is responsible for any research-related costs, identify and estimate the dollar amount.

n/a

11.0 Will participants receive payment (money, gift certificates, coupons, etc.) or be offered incentives (entered into a drawing, class credit) for their participation in this research?

no

12.0 Describe payment and/or incentives to participants.
n/a

13.0 Are you using recruitment materials/scripts?

no, I will speak to each participant individually and review the informed consent.

Appendix B: Treatment consent form

Johns Hopkins University

Homewood Institutional Review Board (HIRB)

Informed Consent Form

Title:	Counselor Competency Assessment for Treating Child Victims of Maltreatment
Principal Investigator:	Donald E. Nowak Jr., PhD, CRC, LMHC-P: Johns Hopkins University
Date:	March 30, 2016

PURPOSE OF RESEARCH STUDY:

The purpose of this research study is to pilot an assessment measure of counselor competency to provide trauma-focused evidenced-based treatment. The results of this evaluation will be used to create a trauma-focused counselor competency assessment to be used to evaluate and improve the training program. The goal of the training program is to increase the availability of trauma-focused evidence-based counseling services for victims and their families by training more providers. We anticipate that approximately three people will participate in this study.

PROCEDURES:

You will be asked to complete pre and post-training assessment to measure your knowledge about trauma treatment. You and your supervisors will also complete rating scales to determine your trauma-focused treatment skills. The pre-assessment occurs at the beginning of the internship/externship and the post-assessment occurs at the end of the internship-externship. Each assessment measure is expected to take approximately 30 minutes to complete.

RISKS/DISCOMFORTS:

The risks associated with participation in this study are no greater than those encountered in other test-taking situations. Participation in this survey is voluntary and if you chose not to participate that will not negatively impact your ability to participate in the intern-training program. The results will not impact your grades.

BENEFITS:

There are no direct benefits to you from participating in this study. The results will help inform a trauma-treatment training program for counselors. Potential benefits include improved assessment and training of counselors therefore better quality treatment for victims to help them heal from their experiences of abuse and neglect.

VOLUNTARY PARTICIPATION AND RIGHT TO WITHDRAW:

Your participation in this study is entirely voluntary: You choose whether to participate. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled. If you choose to participate in the study, you can stop your participation at any time, without any penalty or loss of benefits. If you want to withdraw from the study, please contact April Rectanus via phone at 410-706-1142 or email arectanus@peds.umaryland.edu.

CIRCUMSTANCES THAT COULD LEAD US TO END YOUR PARTICIPATION:

Under certain circumstances we may decide to end your participation before you have completed the study. Specifically, we may stop your participation if your internship placement in terminated.

CONFIDENTIALITY:

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board and officials from government agencies such as the National Institutes of Health and the Office for Human Research Protections. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records. Results are confidential. That means your specific responses will not be shared with anyone other than the researcher who will maintain all copies of the assessment measures and only group results will be reported.

COMPENSATION:

You will not receive any payment or other compensation for participating in this study.

IF YOU HAVE QUESTIONS OR CONCERNS:

You can ask questions about this research study now or at any time during the study, by talking to the researcher(s) working with you or contacting April Rectanus via phone at 410-706-1142 or email arectanus@peds.umaryland.edu. If you have questions about your rights as a participant or feel that you haven't been treated fairly, please call the Homewood Institutional Review Board as Johns Hopkins University at 410-516-6580.

SIGNATURES

WHAT YOUR SIGNATURE MEANS:

Your signature below means that you understand the information in this consent form. Your signature also means that you agree to participate in the study.

By signing this consent form, you have not waived any legal rights you otherwise would have as a participant in a research study.

____

____

Participant's Signature **Date**

____

____

Signature of Person Obtaining Consent **Date**
(Investigator or HIRB Approved Designee)

Appendix C: Trainee Rating Scale

Trauma-Focused Counseling Competency Assessment - Self Rating Scale

Date: _____ Supervisor ID: _____

Student ID number: _____

Directions: Please provide a score from 1 to 8 for each of the following areas based on the descriptions given to determine level of competency achieved. Please note that competency implies both knowledge and skills.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Knowledge of complex trauma	*Multiple interpersonal traumas often experienced during childhood and result in symptoms in many areas such as health, affective, cognitive, behavioral, interpersonal, & academic. Knowledge includes what complex trauma is along with triggers, risk factors, and symptom and how it differs from simple trauma.*	Demonstrate unfamiliarity with complex trauma. Unable to distinguish it from simple trauma.	Have a beginning understanding of what complex trauma is. Unable to identify complex trauma symptoms in clients.	Demonstrate an understanding of complex trauma and able to explain it to others. Beginning to see related symptoms in clients and using complex trauma to conceptualize cases.	Can explain what complex trauma is. Consistently able to recognize the triggers and symptoms of complex trauma in clients and use it as a framework for conceptualizing clients.
	Knowledge of trauma competencies	*Assessment, treatment planning, advocacy, therapeutic environment and relationship, safety, psychoeducation, distress reduction/affect regulation, positive identify, trauma processing, behavioral control, and caregiver support.*	Unable to identify key components of trauma treatment. Limited or no understanding of what the components are.	Able to identify some key trauma competencies, but not able to recognize the components in sessions with clients.	Can identify and explain most of the key components. Able to recognize some of them in sessions with clients.	Can identify and explain all of the key trauma-treatment components. Consistently able to recognize the components in sessions with clients.
	Trauma-Informed Assessment	*Use multiple sources such as symptoms measures (TSI's, CBCL's), reports from other agencies, and clinical interviews to gather risk assessment, trauma history, developmental history, family, strengths, diagnosis, projective measures etc.*	Unable to identify the components of a trauma-informed assessment it. Cannot identify symptoms measures and questions to include.	Able to identify some components of a trauma-informed assessment. Able to conduct assessment with support.	Able to identify most components of a trauma-informed assessment and beginning to conceptualize clients and to conduct	Consistently able to complete trauma-informed assessment independently and to complete a case conceptualization based on the assessment.

		Repeated assessment to monitor progress.			assessment with minimal support.	
Score	**Trauma-focused competencies**	***Descriptions***	**Novice or Does not display competency** **1-2**	**Beginning or Minimal competency** **3-4**	**Advanced beginner or Moderate competency:** **5-6**	**Competent:** **7-8**
	Treatment planning	*Rate treatment priority areas, create short and long-term goals based on assessment data, create measurable goals, regularly review plan for progress, and modify as needed. Collaborate with client/caregivers and family members.*	Unable to identify trauma-related treatment goals and objectives.	Able to identify some trauma-related treatment goals and objectives. Able to create a treatment plan with support.	Able to identify trauma-related treatment goals and objectives. Able to create a treatment plan with minimal support and revaluate treatment plans.	Consistently able to work with client to identify individualized trauma-related treatment goals with objectives and to determine progress on those objectives through regularly monitoring.
	Advocacy/Systems interventions	*Maintain contact with other involved agencies or professionals, advocate in other systems (*i.e.,*school, legal, financial, protective services), link clients to other resources, & reduce barriers to access.*	Demonstrates a lack of understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.	Demonstrates some understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.	Demonstrates understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling. Beginning to engage other systems and to advocate for clients.	Able to explain what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling. Consistently able to engage other systems and to advocate for clients.
	Therapeutic relationship	*Therapist should ensure the relationship is: safe, respectful, culturally responsive, consistent, reliable, supportive yet encourage growth, nonintrusive, empathetic, attuned, honest, respectful, protecting of confidentiality, & understanding.*	Demonstrates a lack of understanding of the importance of a therapeutic relationship. Difficulty building relationship with clients and family members.	Demonstrates a beginning understanding of the importance of a strong therapeutic relationships and how to build one. Able to form positive relationships with some clients and their family members.	Displays understanding of the importance of a strong therapeutic relationships and how to build one. Able to form strong relationships with most clients and their family members.	Able to understand and explain the importance of a strong therapeutic relationship and how to build one. Consistently able to form strong relationships with most clients and their family members.
	Therapy environment	*Physical environment is safe, welcoming, culturally responsive (displays & materials), child-friendly, clean and orderly, and predictable with appropriate therapy materials, consistent*	Demonstrates a lack of awareness of the importance of the therapy environment. Unable to identify the necessary components	Beginning to understand the importance of a positive therapy environment and can identify some of the necessary components.	Understands the importance of a positive therapy environment and can identify most of the necessary components. Able to incorporate most	Able to explain and recognize the importance of a positive therapy environment and the necessary components.

		schedule and therapy room, and free from distraction.	for a positive therapy environment.	Able to incorporate some aspects of a positive therapy environment.	aspects of a positive therapy environment.	Consistently able to create a positive therapy environment.
Score	**Trauma-focused competencies**	***Descriptions***	**Novice or Does not display competency** **1-2**	**Beginning or Minimal competency** **3-4**	**Advanced beginner or Moderate competency:** **5-6**	**Competent:** **7-8**
	Safety	*Environmental risks and suicidal and homicidal assessment and prevention, engaging other systems to protect child/adolescent (*i.e.,*protective services, school, or community services). Address risks related to ongoing maltreatment, violence, drugs/alcohol, gangs, prostitution, and homelessness.*	Demonstrates a lack of understanding of various safety issues including how to assess and respond.	Demonstrates a beginning understanding of various safety issues. Able to assess safety issues and engage other resources to prevent or reduce risk with support.	Demonstrates an understanding of various safety issues. Able to assess safety issues and engage other resources to prevent or reduce risk with minimal support.	Able to recognize and explain the various safety issues. Consistently able to assess safety issues and engage other resources to prevent or reduce risk.
	Psychoeducation	*Prevalence of abuse, why people abuse, typical responses, symptoms as coping skills, and available resources. A variety of media can be used such as books, videos, pamphlets, and verbal information.*	Demonstrates a lack of information on trauma and abuse therefore unable to provide this information to clients/families.	Demonstrates a basic understanding of trauma and abuse. Able to provide psychoeducation to clients with support.	Demonstrates an understanding of trauma and abuse. Able to provide psychoeducation to clients with minimal support.	Understands and can explain information on trauma and abuse. Selects type of presentation as appropriate for each client.
	Distress reduction/ Affect regulation skills	*Distress reduction to reduce acute overwhelming states in sessions or other triggering situation. Includes grounding, relaxation exercises, deep breathing, visualization, mindfulness, meditation, physical activity* *Affect regulation: label and express thoughts and feelings, use positive thinking, and trigger identification and management.*	Demonstrates a lack of information on distress reduction and affect regulation skills. Unable to teach the skills to clients.	Demonstrates a basic understanding of distress reduction and affect regulation skills. Able to teach some skills to clients with support.	Demonstrates an understanding of distress reduction and affect regulation skills. Able to teach most skills to clients with minimal support.	Able to explain distress reduction and affect regulation. Consistently able to demonstrate the skills and teach them to clients.
	Facilitating positive identity	*Includes positive identity development, self-exploration, self-efficacy, and assertiveness. Techniques: safety (psychological and physical), self-exploration, support and affirmation, activities in identity development, engagement in positive experiences, role-plays for social skills, and validation.*	Demonstrates a lack of understanding of what a positive identify is and how to facilitate it.	Demonstrates a basic understanding of what a positive identify is and how to facilitate it. Able to use some interventions for identity development with support.	Demonstrates an understanding of what a positive identity is and how to facilitate it. Able to use several interventions for identity development with minimal support.	Consistently able to facilitate development of a positive identity in clients using a variety of interventions based on clients' needs and strengths.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Trauma processing	*Cognitive and emotional processing through trauma narratives, titrated exposure, cognitive restructuring, and managing dissociative experiences. Must first have relatively safe and stable home environment, positive therapy relationship, and some emotion regulation and feelings identification skills. Client has control over what and how much to process. Titrate the exposure to desensitize and manage the response. Decrease activation as needed. Select methods (*i.e.,*play, trauma narrative, forward-focused processing) based on clients' needs and strengths.*	Demonstrates a lack of understanding of what trauma processing and unable to determine when clients are ready and how to guide them through the process.	Demonstrates a basic understanding of what trauma processing is. Able to determine when clients are ready and to begin the process with support.	Demonstrates an understanding of what trauma processing is. Able to determine when clients are ready and to engage in processing with minimal support. Need support to determine how to titrate the exposure based on the client's needs and strengths.	Can explain what trauma processing is and can determine appropriateness for each clients. Able to guide clients through the processing in sessions using a variety of techniques. Titrates the exposure based on clients' needs and strengths.
	Relational/ Attachment processing	*Use the therapy relationship to address relational and attachment difficulties. The relationship is likely to trigger trauma-related responses. Process and practice news ways in the therapy relationship thereby desensitize the client. For children this work should also be done with caregivers through parenting classes and/or parent-child therapy.*	Demonstrates a lack of understanding about the nature of relationships and attachment problems and unable to create and use a positive therapy relationships to process and desensitize clients to their relational triggers.	Demonstrates a basic understanding of the nature of relationships and attachment problems. Beginning to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship with support.	Understand the nature of relationships and attachment problems. Able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship with minimal support.	Understand and able to explain the nature of relationships and attachment problems. Consistently able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship.
	Behavioral self-control skills	*Address acting out behaviors (including substance abuse and sexualized behaviors) through trigger identification, emotional regulation skills, teaching thought/feeling/behavior triangle and caregiver education. Increased ability to delay tension –reduction behaviors. Help clients to understand the function of the behavior and focus on empowerment.*	Demonstrates a lack of understating of the nature of behavior problems for victims and unable to address them with clients.	Demonstrates a basic understanding of the nature of behavior problems for victims. Beginning to help clients to increase behavioral control skills with support.	Demonstrates an understanding of the nature of behavior problems for victims. Able to help clients to increase behavioral control skills with minimal support.	Understand and able to explain the nature of behavior problems for victims. Consistently able to help clients to increase behavioral control skills.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Caretaker support/family therapy	*Providing support, skill development, psychoeducation on trauma and its effects, and exploring their responses to the children's victimization and subsequent behavioral and emotional responses. Modalities can include group, family, or individual therapies.*	Demonstrates a lack of information on ways to involve caretakers. Unable to provide intervention to caretakers through the child's.	Demonstrates a basic understanding of ways to involve caretakers. Beginning to provide intervention to caretakers with support.	Demonstrates an understanding of ways to involve caretakers. Provide intervention to caretakers using several interventions with minimal support.	Understands and able to explain the importance of and ways to involve caretakers. Consistently able to determine which types of modalities are best and to engage caregivers..
	Self-care	*Understanding vicarious trauma, utilizes self-care, process countertransference in supervision, able to separate own issues from clients*	Demonstrates a lack of information on vicarious trauma. Not engaging in adequate self-care or using supervision to reduce/prevent vicarious trauma. Lacks insight into how own issues effect therapy.	Demonstrates a basic understanding of vicarious trauma. Beginning to engage in self-care or to use supervision to reduce/prevent vicarious trauma. Beginning to explore insight into how own issues effect therapy with prompting.	Demonstrates an understanding of vicarious trauma. Engaging in self-care or use supervision to reduce/prevent vicarious trauma. Explore how own issues effect therapy without prompting	Can explain and recognize vicarious trauma. Engage in self-care and supervision to reduce/prevent vicarious trauma. Consistently displays insight into how own issues effect therapy and able to explore this in supervision.
	Total Score					

Please answer the following questions.

1. Strengths related to complex trauma treatment skills and knowledge:_____

2. Areas to improve related to complex trauma treatment skills and knowledge: _____

3. Please provide feedback on each of the following training components and their impact on trauma-focused knowledge and skills:
    a. Training sessions: _____
    _____
    b. Supervision: _____
    _____
    c. Observation of other clinicians: _____
    _____
    d. Skill Practice with own clients: _____
    _____
4. Please include any other feedback or recommendations: _____
_____

Feedback on the Trauma-Focused Competency Self-Rating Scale

5. Please describe any areas of providing trauma treatment that this measure did not cover: _____
_____
_____
6. Please include any other feedback or recommendations that you have on this assessment measure:_____
_____
_____

Appendix D: Supervisor Rating Scale

Trauma-Focused Counseling Competency Assessment - Supervisor Rating Scale

Date: _____ Supervisor ID: _____

Student ID number: _____

Directions: Please provide a score from 1 to 8 for each of the following areas based on the descriptions given to determine level of competency achieved. Please note that competency implies both knowledge and skills.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Knowledge of complex trauma	*Multiple interpersonal traumas often experienced during childhood and result in symptoms in many areas such as health, affective, cognitive, behavioral, interpersonal, & academic. Knowledge includes what complex trauma is along with triggers, risk factors, and symptom and how it differs from simple trauma.*	Demonstrate unfamiliarity with complex trauma. Unable to distinguish it from simple trauma.	Have a beginning understanding of what complex trauma is. Unable to identify complex trauma symptoms in clients.	Demonstrate an understanding of complex trauma and able to explain it to others. Beginning to see related symptoms in clients and using complex trauma to conceptualize cases.	Can explain what complex trauma is. Consistently able to recognize the triggers and symptoms of complex trauma in clients and use it as a framework for conceptualizing clients.
	Knowledge of trauma competencies	*Assessment, treatment planning, advocacy, therapeutic environment and relationship, safety, psychoeducation, distress reduction/affect regulation, positive identify, trauma processing, behavioral control, and caregiver support.*	Unable to identify key components of trauma treatment. Limited or no understanding of what the components are.	Able to identify some key trauma competencies, but not able to recognize the components in sessions with clients.	Can identify and explain most of the key components. Able to recognize some of them in sessions with clients.	Can identify and explain all of the key trauma-treatment components. Consistently able to recognize the components in sessions with clients.
	Trauma-Informed Assessment	*Use multiple sources such as symptoms measures (TSI's, CBCL's), reports from other agencies, and clinical interviews to gather risk assessment, trauma history, developmental history, family, strengths, diagnosis, projective measures etc. Repeated assessment to monitor progress.*	Unable to identify the components of a trauma-informed assessment it. Cannot identify symptoms measures and questions to include.	Able to identify some components of a trauma-informed assessment. Able to conduct assessment with support.	Able to identify most components of a trauma-informed assessment and beginning to conceptualize clients and to conduct assessment with minimal support.	Consistently able to complete trauma-informed assessment independently and to complete a case conceptualization based on the assessment.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Treatment planning	*Rate treatment priority areas, create short and long-term goals based on assessment data, create measurable goals, regularly review plan for progress, and modify as needed. Collaborate with client/caregivers and family members.*	Unable to identify trauma-related treatment goals and objectives.	Able to identify some trauma-related treatment goals and objectives. Able to create a treatment plan with support.	Able to identify trauma-related treatment goals and objectives. Able to create a treatment plan with minimal support and revaluate treatment plans.	Consistently able to work with client to identify individualized trauma-related treatment goals with objectives and to determine progress on those objectives through regularly monitoring.
	Advocacy/Systems interventions	*Maintain contact with other involved agencies or professionals, advocate in other systems (*i.e.,*school, legal, financial, protective services), link clients to other resources, & reduce barriers to access.*	Demonstrates a lack of understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.	Demonstrates some understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.	Demonstrates understanding of what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling. Beginning to engage other systems and to advocate for clients.	Able to explain what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling. Consistently able to engage other systems and to advocate for clients.
	Therapeutic relationship	*Therapist should ensure the relationship is: safe, respectful, culturally responsive, consistent, reliable, supportive yet encourage growth, nonintrusive, empathetic, attuned, honest, respectful, protecting of confidentiality, & understanding.*	Demonstrates a lack of understanding of the importance of a therapeutic relationship. Difficulty building relationship with clients and family members.	Demonstrates a beginning understanding of the importance of a strong therapeutic relationships and how to build one. Able to form positive relationships with some clients and their family members.	Displays understanding of the importance of a strong therapeutic relationships and how to build one. Able to form strong relationships with most clients and their family members.	Able to understand and explain the importance of a strong therapeutic relationship and how to build one. Consistently able to form strong relationships with most clients and their family members.
	Therapy environment	*Physical environment is safe, welcoming, culturally responsive (displays & materials), child-friendly, clean and orderly, and predictable with appropriate therapy materials, consistent schedule and therapy room, and free from distraction.*	Demonstrates a lack of awareness of the importance of the therapy environment. Unable to identify the necessary components for a positive therapy environment.	Beginning to understand the importance of a positive therapy environment and can identify some of the necessary components. Able to incorporate some aspects of a	Understands the importance of a positive therapy environment and can identify most of the necessary components. Able to incorporate most aspects of a positive therapy environment.	Able to explain and recognize the importance of a positive therapy environment and the necessary components. Consistently able to

				positive therapy environment.		create a positive therapy environment.
Score	**Trauma-focused competencies**	***Descriptions***	**Novice or Does not display competency** **1-2**	**Beginning or Minimal competency** **3-4**	**Advanced beginner or Moderate competency:** **5-6**	**Competent:** **7-8**
	Safety	*Environmental risks and suicidal and homicidal assessment and prevention, engaging other systems to protect child/adolescent (*i.e.,*protective services, school, or community services). Address risks related to ongoing maltreatment, violence, drugs/alcohol, gangs, prostitution, and homelessness.*	Demonstrates a lack of understanding of various safety issues including how to assess and respond.	Demonstrates a beginning understanding of various safety issues. Able to assess safety issues and engage other resources to prevent or reduce risk with support.	Demonstrates an understanding of various safety issues. Able to assess safety issues and engage other resources to prevent or reduce risk with minimal support.	Able to recognize and explain the various safety issues. Consistently able to assess safety issues and engage other resources to prevent or reduce risk.
	Psychoeducation	*Prevalence of abuse, why people abuse, typical responses, symptoms as coping skills, and available resources. A variety of media can be used such as books, videos, pamphlets, and verbal information.*	Demonstrates a lack of information on trauma and abuse therefore unable to provide this information to clients/families.	Demonstrates a basic understanding of trauma and abuse. Able to provide psychoeducation to clients with support.	Demonstrates an understanding of trauma and abuse. Able to provide psychoeducation to clients with minimal support.	Understands and can explain information on trauma and abuse. Selects type of presentation as appropriate for each client.
	Distress reduction/ Affect regulation skills	*Distress reduction to reduce acute overwhelming states in sessions or other triggering situation. Includes grounding, relaxation exercises, deep breathing, visualization, mindfulness, meditation, physical activity* *Affect regulation: label and express thoughts and feelings, use positive thinking, and trigger identification and management.*	Demonstrates a lack of information on distress reduction and affect regulation skills. Unable to teach the skills to clients.	Demonstrates a basic understanding of distress reduction and affect regulation skills. Able to teach some skills to clients with support.	Demonstrates an understanding of distress reduction and affect regulation skills. Able to teach most skills to clients with minimal support.	Able to explain distress reduction and affect regulation. Consistently able to demonstrate the skills and teach them to clients.
	Facilitating positive identity	*Includes positive identity development, self-exploration, self-efficacy, and assertiveness. Techniques: safety (psychological and physical), self-exploration, support and affirmation, activities in identity development, engagement in positive experiences, role-plays for social skills, and validation.*	Demonstrates a lack of understanding of what a positive identify is and how to facilitate it.	Demonstrates a basic understanding of what a positive identify is and how to facilitate it. Able to use some interventions for identity development with support.	Demonstrates an understanding of what a positive identity is and how to facilitate it. Able to use several interventions for identity development with minimal support.	Consistently able to facilitate development of a positive identity in clients using a variety of interventions based on clients' needs and strengths.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Trauma processing	*Cognitive and emotional processing through trauma narratives, titrated exposure, cognitive restructuring, and managing dissociative experiences. Must first have relatively safe and stable home environment, positive therapy relationship, and some emotion regulation and feelings identification skills. Client has control over what and how much to process. Titrate the exposure to desensitize and manage the response. Decrease activation as needed. Select methods (*i.e.,*play, trauma narrative, forward-focused processing) based on clients' needs and strengths.*	Demonstrates a lack of understanding of what trauma processing and unable to determine when clients are ready and how to guide them through the process.	Demonstrates a basic understanding of what trauma processing is. Able to determine when clients are ready and to begin the process with support.	Demonstrates an understanding of what trauma processing is. Able to determine when clients are ready and to engage in processing with minimal support. Need support to determine how to titrate the exposure based on the client's needs and strengths.	Can explain what trauma processing is and can determine appropriateness for each clients. Able to guide clients through the processing in sessions using a variety of techniques. Titrates the exposure based on clients' needs and strengths.
	Relational/ Attachment processing	*Use the therapy relationship to address relational and attachment difficulties. The relationship is likely to trigger trauma-related responses. Process and practice news ways in the therapy relationship thereby desensitize the client. For children this work should also be done with caregivers through parenting classes and/or parent-child therapy.*	Demonstrates a lack of understanding about the nature of relationships and attachment problems and unable to create and use a positive therapy relationships to process and desensitize clients to their relational triggers.	Demonstrates a basic understanding of the nature of relationships and attachment problems. Beginning to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship with support.	Understand the nature of relationships and attachment problems. Able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship with minimal support.	Understand and able to explain the nature of relationships and attachment problems. Consistently able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship.
	Behavioral self-control skills	*Address acting out behaviors (including substance abuse and sexualized behaviors) through trigger identification, emotional regulation skills, teaching thought/feeling/behavior triangle and caregiver education. Increased ability to delay tension –reduction behaviors. Help clients to understand the function of the behavior and focus on empowerment.*	Demonstrates a lack of understating of the nature of behavior problems for victims and unable to address them with clients.	Demonstrates a basic understanding of the nature of behavior problems for victims. Beginning to help clients to increase behavioral control skills with support.	Demonstrates an understanding of the nature of behavior problems for victims. Able to help clients to increase behavioral control skills with minimal support.	Understand and able to explain the nature of behavior problems for victims. Consistently able to help clients to increase behavioral control skills.

Score	Trauma-focused competencies	*Descriptions*	Novice or Does not display competency 1-2	Beginning or Minimal competency 3-4	Advanced beginner or Moderate competency: 5-6	Competent: 7-8
	Caretaker support/family therapy	*Providing support, skill development, psychoeducation on trauma and its effects, and exploring their responses to the children's victimization and subsequent behavioral and emotional responses. Modalities can include group, family, or individual therapies.*	Demonstrates a lack of information on ways to involve caretakers. Unable to provide intervention to caretakers through the child's.	Demonstrates a basic understanding of ways to involve caretakers. Beginning to provide intervention to caretakers with support.	Demonstrates an understanding of ways to involve caretakers. Provide intervention to caretakers using several interventions with minimal support.	Understands and able to explain the importance of and ways to involve caretakers. Consistently able to determine which types of modalities are best and to engage caregivers..
	Self-care	*Understanding vicarious trauma, utilizes self-care, process countertransference in supervision, able to separate own issues from clients*	Demonstrates a lack of information on vicarious trauma. Not engaging in adequate self-care or using supervision to reduce/prevent vicarious trauma. Lacks insight into how own issues effect therapy.	Demonstrates a basic understanding of vicarious trauma. Beginning to engage in self-care or to use supervision to reduce/prevent vicarious trauma. Beginning to explore insight into how own issues effect therapy with prompting.	Demonstrates an understanding of vicarious trauma. Engaging in self-care or use supervision to reduce/prevent vicarious trauma. Explore how own issues effect therapy without prompting	Can explain and recognize vicarious trauma. Engage in self-care and supervision to reduce/prevent vicarious trauma. Consistently displays insight into how own issues effect therapy and able to explore this in supervision.
	Total Score					

Please answer the following questions.

1. Strengths related to complex trauma treatment skills and knowledge:_____

2. Areas to improve related to complex trauma treatment skills and knowledge: _____

3. Please provide feedback on each of the following training components and their impact on trauma-focused knowledge and skills:
    a. Training sessions: _____
    _____
    b. Supervision: _____
    _____
    c. Observation of other clinicians: _____
    _____
    d. Skill Practice with own clients: _____
    _____
4. Please include any other feedback or recommendations: _____
_____

Feedback on the Trauma-Focused Competency Supervisor-Rating Scale

5. Please describe any areas of providing trauma treatment that this measure did not cover: _____
_____
_____
6. Please include any other feedback or recommendations that you have on this assessment measure:_____
_____
_____

Appendix E: Trainee Interview Guide

1. What were the most helpful parts of the internship experience? Describe.
2. What were the least helpful parts? Describe.
3. What was the impact of the training program on our competency to provide trauma-focused treatment for complex trauma?
4. Please provide feedback on each of the following:
    a. Training sessions
    b. Supervision
    c. Observation
    d. Practice
    e. Other:
5. What changes would you recommend?
6. Any other comments/suggestions?

Appendix F: Supervisor Interview Guide

1. Please describe how the students' competency to treat complex trauma changed over the internship.
2. What were the most helpful aspect of the internship program? Why?
3. What were the least helpful parts? Why?
4. Please provide feedback on each of the following:
    a. Training sessions
    b. Supervision
    c. Observation
    d. Practice
    e. Other:
5. What changes would you recommend?
6. Any other comments/suggestions?

Appendix G: Training curriculum

Counselor Intern Training Program for Treating Complex Trauma

Overview of Program

The research suggests that counselors interested in working with trauma victims would improve their competency to provide TF-EBTs by participating in a trauma-focused internship training program that contains multiple components and provides intensive training and experience (Beidas & Kendall, 2010). The Gold Standard Plus Full Educational Model includes instruction for the core concepts, training in TF-EBT, and implementation of a TF-EBT in year-long field placement, supervised by trained supervisor (Layne et al., 2014). The internship model is similar to the apprenticeship model for which Brown, Collins, and Duguid (1989) advocate to improve learning. Following an evidenced-based training model, the intern training program will include instruction for the core concepts of trauma treatment, training in TF-EBTs, and implementation of a TF-EBT in field placement, supervised by trained supervisor (Layne et al., 2014). Trainers will use strategies from the learning sciences. Trainees will observe supervisors and other experienced counselors and will receive group and individual supervision as well as consultation from experts. Trainees will practice skills on their own caseloads while receiving feedback from their supervisors to improve their competency (Couturier et al., 2014; Ghafoori & Davaie, 2012). Competency assessments and symptom measures will be used to evaluate the training program (McManus et al., 2015). Both self-report and supervisor ratings will be used to obtain a more complete picture of counselor competency (McManus et al., 2015; Swank, 2014). By training more counselors to provide TF-EBTs, more victims can have access to high quality services to help them heal.

Program Components

The program consists of several components including didactic training sessions in trauma competencies and treatment, observation of other clinicians, supervision, and practice with feedback.

Trauma-focused competencies	***Description***	**Goal**
Knowledge of complex trauma	*Multiple interpersonal traumas often experienced during childhood and result in symptoms in many areas such as health, affective, cognitive, behavioral, interpersonal, & academic. Knowledge includes what complex trauma is along with triggers, risk factors, and symptom and how it differs from simple trauma.*	Can explain what complex trauma is. Consistently able to recognize the triggers and symptoms of complex trauma in clients and use it as a framework for conceptualizing clients.
Knowledge of trauma competencies	*Assessment, treatment planning, advocacy, therapeutic environment and relationship, safety, psychoeducation, distress reduction/affect regulation, positive identify, trauma processing, behavioral control, and caregiver support.*	Can identify and explain all of the key trauma-treatment components. Consistently able to recognize the components in sessions with clients.
Trauma-Informed Assessment	*Use multiple sources such as symptoms measures (TSI's, CBCL's), reports from other agencies, and clinical interviews to gather risk assessment, trauma history, developmental history, family, strengths, diagnosis, projective measures etc. Repeated assessment to monitor progress.*	Consistently able to complete trauma-informed assessment independently and to complete a case conceptualization based on the assessment.
Treatment planning	*Rate treatment priority areas, create short and long-term goals based on assessment data, create measurable goals, regularly review plan for progress, and modify as needed. Collaborate with client/caregivers and family members.*	Consistently able to work with client to identify individualized trauma-related treatment goals with objectives and to determine progress on those objectives through regularly monitoring.
Advocacy/Systems interventions	*Maintain contact with other involved agencies or professionals, advocate in other systems (*i.e.,*school, legal, financial, protective services), link clients to other resources, & reduce barriers to access.*	Able to explain what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.

		Consistently able to engage other systems and to advocate for clients.
Therapeutic relationship	*Therapist should ensure the relationship is: safe, respectful, culturally responsive, consistent, reliable, supportive yet encourage growth, nonintrusive, empathetic, attuned, honest, respectful, protecting of confidentiality, & understanding.*	Able to understand and explain the importance of a strong therapeutic relationship and how to build one. Consistently able to form strong relationships with most clients and their family members.
Therapy environment	*Physical environment is safe, welcoming, culturally responsive (displays & materials), child-friendly, clean and orderly, and predictable with appropriate therapy materials, consistent schedule and therapy room, and free from distraction.*	Able to explain and recognize the importance of a positive therapy environment and the necessary components. Consistently able to create a positive therapy environment.
Safety	*Environmental risks and suicidal and homicidal assessment and prevention, engaging other systems to protect child/adolescent (*i.e.,*protective services, school, or community services). Address risks related to ongoing maltreatment, violence, drugs/alcohol, gangs, prostitution, and homelessness.*	Able to recognize and explain the various safety issues. Consistently able to assess safety issues and engage other resources to prevent or reduce risk.
Psychoeducation	*Prevalence of abuse, why people abuse, typical responses, symptoms as coping skills, and available resources. A variety of media can be used such as books, videos, pamphlets, and verbal information.*	Understands and can explain information on trauma and abuse. Selects type of presentation as appropriate for each client.
Distress reduction/ Affect regulation skills	*Distress reduction to reduce acute overwhelming states in sessions or other triggering situation. Includes grounding, relaxation exercises, deep breathing, visualization, mindfulness, meditation, physical activity* *Affect regulation: label and express thoughts and feelings, use positive thinking, and trigger identification and management.*	Able to explain distress reduction and affect regulation. Consistently able to demonstrate the skills and teach them to clients.
Facilitating positive identity	*Includes positive identity development, self-exploration, self-efficacy, and assertiveness. Techniques: safety (psychological and physical), self-exploration, support and affirmation, activities in identity development, engagement in positive experiences, role-plays for social skills, and validation.*	Consistently able to facilitate development of a positive identity in clients using a variety of interventions based on clients' needs and strengths.
Trauma processing	*Cognitive and emotional processing through trauma narratives, titrated exposure, cognitive restructuring, and managing dissociative experiences. Must first have relatively safe and stable home environment, positive therapy relationship, and some emotion regulation and feelings identification skills. Client has control over what and how much to process. Titrate the exposure to desensitize and manage the response. Decrease activation as needed. Select methods (*i.e.,*play, trauma narrative, forward-focused processing) based on clients' needs and strengths.*	Can explain what trauma processing is and can determine appropriateness for each clients. Able to guide clients through the processing in sessions using a variety of techniques. Titrates the exposure based on clients' needs and strengths.
Relational/ Attachment processing	*Use the therapy relationship to address relational and attachment difficulties. The relationship is likely to trigger trauma-related responses. Process and practice news ways in the therapy relationship thereby desensitize the client. For children this work should also be done with caregivers through parenting classes and/or parent-child therapy.*	Understand and able to explain the nature of relationships and attachment problems. Consistently able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship.
Behavioral self-control skills	*Address acting out behaviors (including substance abuse and sexualized behaviors) through trigger identification, emotional regulation skills, teaching thought/feeling/behavior triangle and caregiver education. Increased ability to delay tension –reduction behaviors. Help clients to understand the function of the behavior and focus on empowerment.*	Understand and able to explain the nature of behavior problems for victims. Consistently able to help clients to increase behavioral control skills.
Caretaker support/family therapy	*Providing support, skill development, psychoeducation on trauma and its effects, and exploring their responses to the children's victimization and subsequent behavioral and emotional responses. Modalities can include group, family, or individual therapies.*	Understands and able to explain the importance of and ways to involve caretakers. Consistently able to determine which types of modalities are best and to engage caregivers..

Self-care	*Understanding vicarious trauma, utilizes self-care, process countertransference in supervision, able to separate own issues from clients*	Can explain and recognize vicarious trauma. Engage in self-care and supervision to reduce/prevent vicarious trauma. Consistently displays insight into how own issues effect therapy and able to explore this in supervision.

Curriculum

Orientation

All students have a two-week orientation period in which they participate in training sessions and observe other clinicians. Students are given an orientation checklist.

Program Policies and Procedures

Leave time, scheduling, opening and closing the clinic, policy and procedure manual, overview of division and position responsibilities, obtaining supplies, referral criteria and process. Getting ID and parking.

Technology

Email, scheduling, connecting to printers, accessing email remotely, using database/software, using camera/recording sessions, bug-in-ear device, navigating the shared drive.

Charts/forms

Required notes and reports, review charts and notes/reports, how to write notes, location of forms, review of consents, overview of chart format

Play Therapy

Watch two play therapy videos.

Observation

Observe supervisors and other experienced counselors conducting individual or family therapy and intake sessions including feedback. Must observe at least one and co-lead at least on intake before can take the lead on own intake.

Trauma Treatment Competencies

Trainings occur in the first semester beginning with a two-week (4 days) orientation and continue weekly (60-min sessions) for the first 15 weeks. Training sessions will first teach general trauma competencies for treating children and then students will be trained using the Integrative Treatment for Complex Trauma (ITCT) model (Lanktree & Briere, 2008). Core competencies for childhood trauma, which will be taught during orientation, address the complexity and context of trauma, secondary adversities, various reactions to trauma, importance of addressing safety, impact of trauma on caregiving systems, protective factors, negative impact of trauma on development, involvement of neurobiology for trauma responses, impact of culture on trauma response, social implications, and issues related to vicarious trauma (NCTSN, 2012). Then weekly training sessions during the first semester will cover the ITCT model with one 60-minutes session for each of the following components: understanding complex trauma, assessment, advocacy, therapeutic relationship, safety, affect regulation,

identity development, psychoeducation, cognitive and emotional processing, relational processing, behavior self-control, interventions with caregivers, family therapy, and self-care (Lanktree & Briere, 2008).

Session 1: Knowledge of complex trauma

Definition: Multiple interpersonal traumas often experienced during childhood and result in symptoms in many areas such as health, affective, cognitive, behavioral, interpersonal, & academic. Knowledge includes what complex trauma is along with triggers, risk factors, and symptom and how it differs from simple trauma. Layne et al. (2011) divided the core trauma concepts into three domains; understanding the trauma experience (i.e.,the complex processes), the consequences (i.e.,involvement of the nervous system), and principals for interventions (i.e.,awareness of vicarious trauma).

Goal: Can explain what complex trauma is. Consistently able to recognize the triggers and symptoms of complex trauma in clients and use it as a framework for conceptualizing clients.

Session outline: (Use Trauma in Children and Families powerpoint presentation)

1. As what a trauma is and then clarify with the definition from DSM-V
2. Ask for differentiation of complex and simple trauma. Compare and contrast
3. Define child maltreatment - definitions, impacts, etc
4. Review diagnostic criteria for PTSD
5. Explored symptoms of developmental trauma disorder/complex trauma - – Van der Kolk
6. Identify risk factors (ITCT-C lists)
    a. Relationship to abuser
    b. Intensity of abuse, etc
    c. Losses associated with abuse
    d. Medical injuries or conditions
    e. Self-blame/shame
    f. History of other traumas
    g. Premorbid functioning
    h. Cognitive/developmental delays
    i. Insecure attachment
    j. Age of first trauma experience
    k. Lack of community safety, poverty
    l. Culture and gender considerations
7. Review impact of trauma on the brain – article from Carrion & Wong, 2012 and Pollak, 2011
    a. Carrion & Wong (2012): Methods: researchers used magnetic resonance imaging (MRI) to compare youth with PTSS and gender-matched healthy children (40 pairs). Results:
        i. smaller and less active hippocampus for those with trauma therefore poorer memory processing
        ii. hippocampus involved in avoidance & numb symptoms
        iii. changes in size of several areas of PFC – some smaller & some bigger

iv. less brain volume for several areas (total brain tissues, cerebral gray matter)
v. deficits in PFC that affect attention control, memory, response inhibition, & emotional reason therefore impact learning and therapy process
vi. therapy can result in positive changes in those regions

b. Pollack (2011): illustrations from the study of maltreated children.
i. abused children are hypersensitive to angry faces & attend to threatening stimuli while ignoring other stimuli
ii. maltreatment impairs brain development
iii. difficulty down-regulating after stressor & shifting attention away if not relevant
iv. negative effects on the limbic hypothalamic pituitary adrenal (L-HPA) system that respond to perceived threat therefore affects energy level, immunity, arousal, and cognition
v. lower levels of oxytocin
vi. amygdala (threat response) is hyper-responsive

Session 2: Knowledge of trauma competencies

Definition: Assessment, treatment planning, advocacy, therapeutic environment and relationship, safety, psychoeducation, distress reduction/affect regulation, positive identify, trauma processing, behavioral control, and caregiver support.

Goal: Can identify and explain all of the key trauma-treatment components. Consistently able to recognize the components in sessions with clients.

Session outline: (Core Components handout)

1. Review complex trauma symptoms.
2. Have trainees identify as many competencies as they can for treating complex trauma in children
3. Examine core trauma competencies (NCTSN), TF-CBT and ITCT components – compare and contrast (Provide and review Core Components handout)
4. Discusses what evidenced-based or trauma-informed means
5. Identify other TF-EBTs for child maltreatment
    a. TF-CBT (remind the to do this training ASAP)
    b. Abuse-focused CBT
    c. Triple P
    d. PCIT
    e. CPP
6. Have each trainee create their own concept map for trauma treatment components

Sessions 3 & 4: Trauma-Informed Assessment

Use multiple sources such as symptoms measures (TSI's, CBCL's), reports from other agencies, and clinical interviews to gather risk assessment, trauma history, developmental history, family, strengths, diagnosis, projective measures etc. Repeated assessment to monitor progress. Scoring and interpreting measures, completing genograms, informed consent, etc.

Goal: Consistently able to complete trauma-informed assessment independently and to complete a case conceptualization based on the assessment.

Outline: (2-part or a 2-hour session during orientation): Give intake packet including intake evaluations, consents, mental status, and assessment measures). Focus on assessment in second part.

1. Discuss importance of assessment
    a. To guide treatment
    b. As a baseline
2. Review intake process – show checklist
3. Review consents
4. Components of psychosocial history - trauma history, strengths, presenting issues, goals, and birth/development, social, school, health, legal, and family history. (show intake form)
5. Projective drawings – role-play
    a. HTP
    b. Kinetic family or family as animals
    c. Bird's nest
6. Parent-child observation
    a. CDI
    b. PDI
    c. Clean-up
7. Play therapy – non directive
8. Mental status exams –briefly show several examples for children and adults (they should have learning some in school)
    a. Show the Clinician's Thesaurus
    b. MSE
    c. SLUMS
    d. MOCA
    e. Revisions for children
9. Administering, scoring, and interpreting assessment measure measures (separate session by psychologist). CBCL's, TSI's, ECBI, Connors/Vanderbilt's, DES, etc.
    a. Administration
    b. Scoring
    c. interpretation
10. Write-up - review examples
11. Diagnosis – review list common diagnosis for victims of child maltreatment and present sample cases(they should have studied these in school)
    a. PTSD
    b. Adjustment D/O
    c. Attachment disorders
    d. ADHD
    e. Depression
    f. Anxiety

Session 5: Safety

Environmental risks and suicidal and homicidal assessment and prevention, engaging other systems to protect child/adolescent (i.e.,protective services, school, or community services). Address risks related to ongoing maltreatment, violence, drugs/alcohol, gangs, prostitution, and homelessness.

Goal: Able to recognize and explain the various safety issues. Consistently able to assess safety issues and engage other resources to prevent or reduce risk.

Outline: Safety component presentation

1. Risk assessment
    a. Areas – SI, HI, self-harm, risky sexual behaviors, drug abuse, on-going abuse, basic needs, aggressive/dangerous behaviors
    b. Explore some questions to ask for each of those areas – see their ideas and offer others
    c. role play, must always consult with a licensed clinician
2. Define each type of child maltreatment
3. When and how to report to CPS
4. Policies and procedures for risk issues – consult with supervisor/LC, internal reporting, contacting risk management, documentation
5. Discuss safety planning, provide examples (see Sidran worksheets)
6. Explore possible interventions (i.e.,crisis hotlines, safety planning, consult, hospitalize, How to hospitalize
7. Confidentiality issues

Session 6: Treatment planning

Rate treatment priority areas, create short and long-term goals based on assessment data, create measurable goals, regularly review plan for progress, and modify as needed. Collaborate with client/caregivers and family members.

Goal: Consistently able to work with client to identify individualized trauma-related treatment goals with objectives and to determine progress on those objectives through regularly monitoring.

Outline: (no presentation; handouts & review book)

1. Review common symptom, diagnoses, and treatment component for complex trauma.
2. Discuss the difference between goals and objectives (handout).
3. Show treatment planning book, samples goals and objectives for IEPS
4. Using sample cases, practice creating treatment goals and objectives

Session 7: Advocacy/Systems interventions

Maintain contact with other involved agencies or professionals, advocate in other systems (i.e.,school, legal, financial, protective services), link clients to other resources, & reduce barriers to access. Able to explain what advocacy and systems interventions are, why they are important to clients, and how they are relevant to trauma counseling.

Goal: Consistently able to engage other systems and to advocate for clients.

Outline: use Advocacy & Systems Intervention presentation

1. Discuss social justice and advocacy – what it is and what is included.
2. Discuss barriers to access and possible interventions (reminder calls, child care, transport, food, follow up for no shows)
3. Explore possible resources and how to find them(UW 511 and MDCSL)
4. Talk about role of community outreach worker
5. Provide information about IEP meetings
6. Explore role for court proceedings (recommendations for CINA hearing, support and recommendation for trials)

Session 8: Therapeutic relationship

Therapist should ensure the relationship is: safe, respectful, culturally responsive, consistent, reliable, supportive yet encourage growth, nonintrusive, empathetic, attuned, honest, respectful, protecting of confidentiality, & understanding.

Goal: Able to understand and explain the importance of a strong therapeutic relationship and how to build one. Consistently able to form strong relationships with most clients and their family members.

Outline: (**30-min**) Therapy environment presentation

1. Review involvement of relationships in complex trauma and symptoms
2. Show "Every Kid Deserves a Champion" video
3. Explore how video connect to therapeutic work
4. Discuss ways to create a positive relationship with clients and family members
5. Move on to Therapy Environment session

Session 8: Therapy environment

Physical environment is safe, welcoming, culturally responsive (displays & materials), child-friendly, clean and orderly, and predictable with appropriate therapy materials, consistent schedule and therapy room, and free from distraction.

Goal: Able to explain and recognize the importance of a positive therapy environment and the necessary components. Consistently able to create a positive therapy environment.

Outline: (**30-min**) Therapy environment presentation

1. Discuss why the environment is important
2. Identify ways to improve the environment
3. Talk about ways to set up the therapy room – key items, organization, etc.

Session 9: Psychoeducation

Definition: Presenting information on prevalence of abuse, why people abuse, typical responses, symptoms as coping skills, and available resources. A variety of media can be used such as books, videos, pamphlets, and verbal information.

Goal: Understands and can explain information on trauma and abuse. Selects type of presentation as appropriate for each client.

Outline: Present fact sheets on the different types of child maltreatment from NCTSN & Child Welfare Information Gateway

1. First ask trainees and then present the correct information about the following
2. Definitions of child abuse and IPV (see handouts)
3. Prevalence
4. Why people abuse/risk factors
5. Review symptoms and frame as coping skills
6. Show some examples such as court workbook and books for children on maltreatment
7. Identify any other information that victims needs to know
8. Role play explaining to children and caregivers

Sessions 10 & 11: Distress reduction/Affect regulation skills

Definition: Distress reduction to reduce acute overwhelming states in sessions or other triggering situation. Includes grounding, relaxation exercises, deep breathing, visualization, mindfulness, meditation, physical activity

Affect regulation: label and express thoughts and feelings, use positive thinking, and trigger identification and management.

Goal: Able to explain distress reduction and affect regulation. Consistently able to demonstrate the skills and teach them to clients.

Outline: Use Distress Reduction and Affect Regulation presentation. Focus on distress reduction in first session and affect regulation in second.

1. Explore the difference between distress reduction and affect regulation
2. Role play and take turns leading deep breathing, grounding, visualization, mindfulness, and muscle relaxation activities. (esp belly breathing, safe space, & grounding)
3. Review sample activities to teach thoughts and feelings, self-talk and trigger identification (games, art, worksheets, body sensations & posters).
4. Show where resources are kept.

Session 12: Facilitating positive identity

Definition: Includes positive identity development, self-exploration, self-efficacy, and assertiveness. Techniques: safety (psychological and physical), self-exploration, support and affirmation, activities in identity development, engagement in positive experiences, role-plays for social skills, and validation.

Goal: Consistently able to facilitate development of a positive identity in clients using a variety of interventions based on clients' needs and strengths.

Outline: (**30-min**) Presentation on Facilitating Positive Identity & Relational Processing

1. Discuss what positive identity is.
2. Examine ways to improve identity.
3. Show samples for collage, anagram, etc. Have them create an anagram and/or a self-portrait
4. Go into Relational Processing session

Session 12: Relational/ Attachment processing

Definition: Use the therapy relationship to address relational and attachment difficulties. The relationship is likely to trigger trauma-related responses. Process and practice news ways in the therapy relationship thereby desensitize the client. For children this work should also be done with caregivers through parenting classes and/or parent-child therapy.

Goal: Understand and able to explain the nature of relationships and attachment problems. Consistently able to use the therapy relationships to process and desensitize clients. Able to engage caregivers when appropriate to improve the parent-child relationship.

Outline: (**30-min**) Presentation on Facilitating Positive Identity & Relational Processing

1. Review how complex trauma effects relationships.
2. Explore how can use therapy relationship to process relational trauma
3. Identify signs of relational issues
4. List ways to address relational issues in sessions

Session 13: Trauma processing

Cognitive and emotional processing through trauma narratives, titrated exposure, cognitive restructuring, and managing dissociative experiences.

Must first have relatively safe and stable home environment, positive therapy relationship, and some emotion regulation and feelings identification skills.

Client has control over what and how much to process. Titrate the exposure to desensitize and manage the response. Decrease activation as needed. Select methods (i.e.,play, trauma narrative, forward-focused processing) based on clients' needs and strengths.

Goal: Can explain what trauma processing is and can determine appropriateness for each clients. Able to guide clients through the processing in sessions using a variety of techniques. Titrates the exposure based on clients' needs and strengths.

Outline: Give Trauma Narrative packet with L. Lowenstein's & E. Gentry's information

1. Ask what trauma processing means
2. Discuss why it's important – review related research
3. Explain titration and desensitization
4. Determining readiness and intensity of trauma exposure
5. Review different methods for processing trauma (My Story, play therapy, Eric Gentry's stuff, EMDR)
6. Show examples of trauma narratives
7. What to watch for and how to respond (abreactions – grounding)
8. Have trainees complete online TF-CBT training and TG-CBT training

Session 14: Behavioral self-control skills

Definition: Address acting out behaviors (including substance abuse and sexualized behaviors) through trigger identification, emotional regulation skills, teaching thought/feeling/behavior triangle, and caregiver education. Increased ability to delay tension –reduction behaviors. Help clients to understand the function of the behavior and focus on empowerment.

Goal: Understand and able to explain the nature of behavior problems for victims. Consistently able to help clients to increase behavioral control skills.

Outline: Presentation "Behavioral Self-control Skills" along with Trigger Grid (ITCT), Diary Cards & Behavior chain analysis (DBT), and Plan to Modify Sexual Behaviors.

1. Explore the function of acting out behaviors.
2. Identify client-directed interventions: trigger identification, emotional regulation skills, teaching thought/feeling/behavior triangle, delay TRB, substance abuse, behavior chain analysis
3. Identify caregiver-directed interventions: education, behavioral contracts, plan to modify sexual behaviors
4. Role play

Session 15: Caretaker support/family therapy

Definition: Providing support, skill development, psychoeducation on trauma and its effects, and exploring their responses to the children's victimization and subsequent behavioral and emotional responses. Modalities can include group, family, or individual therapies.

Goal: Understands and able to explain the importance of and ways to involve caretakers. Consistently able to determine which types of modalities are best and to engage caregivers.

Outline:

1. Discuss the difference between parent involvement in the child's therapy and family therapy.
2. Identify parent involvement strategies: check-ins, child teach the parent coping skills they learn, psychoeducation for caregivers, and presenting trauma narrative
3. Discuss basics to family therapy including CPP and PCIT, process orientated, communication interventions
4. Conduct PCIT training (8 sessions)

Session 16: Self-care

Definition: Understanding vicarious trauma, utilizes self-care, process countertransference in supervision, able to separate own issues from clients Can explain and recognize vicarious trauma. Goal: Engage in self-care and supervision to reduce/prevent vicarious trauma. Consistently displays insight into how own issues effect therapy and able to explore this in supervision.

Outline: Conduct VT & VPTG training

Supervision

Trainees will receive weekly group and individual supervision to provide support and feedback to trainees (Couturier et al., 2014; Ghafoori & Davaie, 2012; O'Byrne & Rosenberg, 1998). Supervision begins during the first week of the internship and continues weekly throughout the placement.

Individual supervision

Students receive one hour of individual and one hour of group supervision per week using a reflective supervision model (Heller & Gilkerson, 2009). Individual supervision is provided by either a licensed clinical psychologist or a licensed marriage and family therapist. During individual supervisors provide feedback to trainees on their skills based on case discussion, observation, and review of clinical notes and reports. Supervisors complete mid semester and end of semester evaluations with the interns in which they rate students on a variety of clinical and professional items and provide feedback to interns on their skills. This data will also be used to evaluate the training program. Students also receive on-going consultation from the other clinicians.

Group supervision

1 hour per week through MDT Group supervision is conducted during multidisciplinary team meetings in which the team discusses cases and provides feedback. The team meetings are led by the researcher, who is the program director and licensed clinical professional counselor, and include the students, a psychiatrist, psychologist, marriage and family therapist, consultant on mental health for young children, and a community outreach worker. Students also receive on-going consultation as needed from their supervisor and the team (i.e.,psychiatrist, psychologist, marriage and family therapist, licensed clinical professional counselor, consultant, and pediatrician).

Practice with feedback

Each trainee will have 6-8 cases in order to practice their trauma-focused skills. A case is an individual client for whom the counselor provides individual and/or family therapy and advocacy. Each client is typically seen once per week and sessions focused on addressing treatment priority areas using treatment components as indicated by the ITCT model (Lanktree & Briere, 2013). For example a counselor may teach coping skills to address affect regulation and facilitate completion of a trauma narrative to alleviate symptoms of post-traumatic stress. Trainees should record all sessions for which they have permission. Trainees are responsible for charting all contacts and competing clinical documentation for their clients (i.e.,evaluations, treatment planning, and treatment updates, and discharge summaries). Trainees then discuss cases in individual and group supervisions to obtain feedback to improve their skills. They must also provide session recording and clinical documents to their supervisors for review.

Appendix H: Training Slides

Intern Training Program

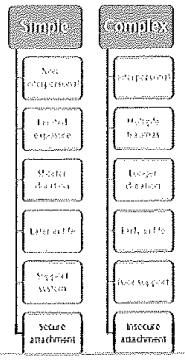
Trauma in Children and Families

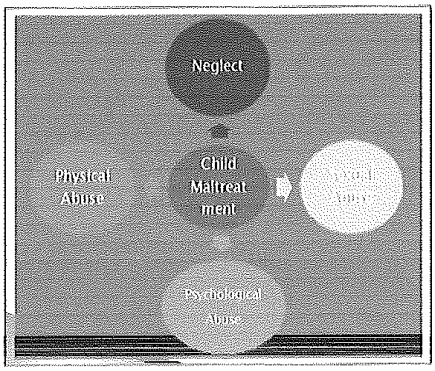
April Reckamp, MA, LCPC

What is trauma?

- Exposure to actual or threatened
  - Death
  - Serious injuring
  - Sexual violation
- Exposure =
  - Direct experience
  - Witness in person
  - Learn it happened to close family member/friend
  - Repeated or extreme exposure to aversive details

Trauma Types





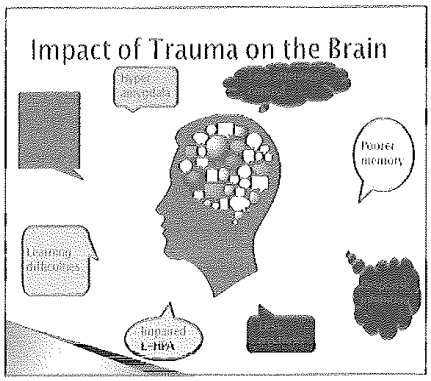
Posttraumatic Stress Disorder (PTSD)

- Re-experiencing
- Avoidance
- Hyperarousal
- Negative mood and cognitions
- Duration more than 1 month
- Causes significant impairment

(DSM-5, 2013)

Developmental/Complex Trauma Disorder

- Exposure to trauma
- Emotional dysregulation
- Somatic (physical) dysregulation
- Cognitive dysregulation
- Behavioral dysregulation
- Self and Relational dysregulation
- symptoms of PTSD
- Impairment



Risk Factors for PTSD

- Relationship to abuser
- Intensity of abuse, etc
- Losses associated with abuse
- Medical injuries or conditions
- Self-blame/shame
- History of other traumas
- Premorbid functioning
- Cognitive/developmental delays
- Insecure attachment
- Age of first trauma experience
- Lack of community safety, poverty
- Culture and gender considerations

(Kaufman & Rincon, 2008)

Core Components of Interventions

- Motivational interviewing (to engage clients)
- Risk screening (to identify high-risk clients)
- Triage to different levels and types of intervention (to match clients to the interventions that will most likely benefit them/they need)
- Systematic assessment, case conceptualization, and treatment planning (to tailor intervention to the needs, strengths, circumstances, and wishes of individual clients)
- Engagement/addressing barriers to service-seeking (to ensure clients receive an adequate dosage of treatment in order to make sufficient therapeutic gains)
- Psychoeducation about trauma reminders and loss reminders (to strengthen coping skills)
- Psychoeducation about posttraumatic stress reactions and grief reactions (to strengthen coping skills)
- Teaching emotional regulation skills (to strengthen coping skills)
- Maintaining adaptive routines (to promote positive adjustment at home and at school)
- Parenting skills and behavior management (to improve parent-child relationships and to improve child behavior)
- Constructing a trauma narrative (to reduce posttraumatic stress reactions)
- Teaching safety skills (to promote safety)
- Advocacy on behalf of the client (to improve client support and functioning at school, in the juvenile justice system, and so forth)
- Teaching relapse prevention skills (to maintain treatment gains over time)
- Monitor client progress/response during treatment (to detect and correct insufficient therapeutic gains in timely ways)
- Evaluate treatment effectiveness (to ensure that treatment produces changes that matter to clients and other stakeholders, such as the court system)

In contrast, interventions that do not include needed core components may be inappropriate for the population or may require substantial adaptation.

NCTSN.org
http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

Core Competencies for childhood trauma

- the complexity and context of trauma,
- secondary adversities,
- various reactions to trauma,
- importance of addressing safety,
- impact of trauma on caregiving systems,
- protective factors,
- negative impact of trauma on development,
- involvement of neurobiology for trauma responses,
- impact of culture on trauma response,
- social implications, and
- issues related to vicarious trauma

(NCTSN, 2012).

Core Components of TF-CBT

- Psychoeducation
- Parenting skills
- Relaxation/stress management
- Affective expression and modulation
- cognitive coping and processing
- Trauma narration
- Safety planning

How to Implement TF-CBT - NCTSN
http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf

Core Components of ITCT

- understanding complex trauma,
- assessment, advocacy,
- therapeutic relationship,
- safety,
- affect regulation,
- identity development,
- psychoeducation,
- cognitive and emotional processing,
- relational processing,
- behavior self-control,
- interventions with caregivers,
- family therapy, and
- self-care

ITCT-A (Briere & Lanktree, 2013) & ICTC-C manuals (Lanktree & Briere, 2008).

Evidenced-based treatments for child maltreatment

- TF-CBT
- Abuse-focused CBT
- PCIT
- CPP
- Triple P

Allen, B., Gharagozloo, L., & Johnson, J.C. (2012). Clinician knowledge and utilization of empirically-supported treatments for maltreated children. *Child Maltreatment, 17*, 11-21. doi: 10.1177/1077559511426333

UNIVERSITY of MARYLAND
CHILDREN'S HOSPITAL

The Care Clinic
520 W. Lombard St, Gray Hall, Ground Floor
Baltimore, MD 21201

Child/Adolescent Intake Form

This information is to be completed at intake by the therapist and then should be inputted into evaluation form. If the intake is not completed then this form should remain in the file.

Child/Adolescent Name:	Age:	Today's date:
Source of information:	Relationship to child:	

Presenting Issues:

Trauma History: (mark all that apply)

☐ Physical abuse
☐ Neglect
☐ Accidents
☐ Community violence
☐ Sexual abuse
☐ Exposure to domestic violence
☐ Natural disasters
☐ Other: _____

Description: _____

Other stressful life events: (mark all that apply)

☐ Divorce of parents
☐ Separation/Loss
☐ Frequent moves
☐ Poverty
☐ Change in caregiver(s) (e.g., foster care)
☐ Homelessness
☐ other: _____

Description: _____

Symptoms: (mark all that apply)

☐ Physical complaints
☐ Mood disturbance
☐ Nightmares
☐ Changes in appetite/eating patterns
☐ Aggression to self/others/property
☐ Suicidal ideation
☐ Enuresis/encopresis
☐ Sexual behaviors/sexuality concerns
☐ Anger/irritability
☐ Fear/worries/anxiety
☐ Sleep problems
☐ Flashbacks/intrusive thoughts or memories
☐ Self-harm behaviors
☐ Problems with relationships/social skills
☐ School problems
☐ Other: _____

When did these problems start? _____

Describe problems: _____

What copings skills and interests does the child have? _____

_____

What are the child's strengths and supports? _____

_____

What are the child and family's goals for their treatment? _____

_____

Psychosocial History:

Pregnancy was: ☐ planned ☐ unplanned Pregnancy lasted: _____ weeks
☐ normal ☐ complications (#)

If complications, describe: _____

_____

Mother's health during pregnancy:
☐ Normal (no concerns) ☐ Used alcohol/drugs ☐ On bed-rest ☐ Other

Describe: _____

_____

Child was delivered: ☐ Vaginally ☐ C-Section

Birth weight: _____ lbs, _____ oz. Birth length: _____ inches

How was the child as a baby (e.g., fussy/colicky, difficult, content) _____

_____

Age at which child…

Said first word: _____ Started speaking in sentences: _____

Started crawling: _____ Started walking: _____

Was toilet-trained: _____

Any issues with the above? Describe: _____

_____

Who lives in the home with the child (number of individuals and relation): _____

_____

Sleep habits…

Time that child usually… goes to sleep: _____ wakes up: _____

Sleep concerns: ☐ Trouble falling asleep ☐ Wakes up at night ☐ Nightmares

Where and with whom does the child sleep at night? _____

Describe: _____

_____

Eating habits…

Child eats (#)_____ meals each day ☐ Snacks frequently

Any food allergies: _____

Other eating concerns (including restriction, binging, or purging): _____

_____

How does your child tend to their hygiene (i.e. brushing teeth, bathing, toileting, etc) and chores?
☐Excellent ☐ Good ☐ Poor: Explain:_____

How is the child's health? ☐Excellent ☐ Good ☐ Poor: Explain:_____

For older children/adolescents:
When was the onset of puberty (menarche/semenarche)? _____
Is the adolescent currently, or has he/she ever been, sexually active? If so, how many partners has he/she had? ☐No ☐Yes Number of partners: _____ Describe any concerns: _____

Does the adolescent use, or has he/she ever used, drugs or alcohol (illegal or misuse of prescription)? ☐No ☐Yes: Describe type, frequency, onset, and consequences: _____

Does the child take any medications: ☐No ☐Yes: list _____

List any significant illnesses/injuries that the child has had: _____

Previous counseling/therapy for child: _____

Grade in School: _____ Name of School:_____
List any special school services received: _____
Child has… ☐ skipped a grade ☐ held back a grade List:_____
Describe any school problems or successes: _____

How does the child get along with…
…parents/family?: ☐ Better than average ☐ Average ☐ Worse than average
…other children? ☐ Better than average ☐ Average ☐ Worse than average
For older/children adolescents:
Does the adolescent date? ☐Yes ☐No Is there a current romantic partner? ☐Yes ☐No
Describe: _____

Does the child have any other legal involvement (including custody issues/visitation agreement)? ☐No ☐Yes If yes, please explain _____

List any other concerns: _____

Family History:

Please list all the people who are close to the child.

Name	Relationship to child	Age/DOB	Live with child?

Family medical history: _____

Family psychiatric/substance abuse history: _____

Family legal history (include any reported/suspected child abuse/neglect and CPS involvement): _____

Parent(s) employment/educational history (i.e. highest degree earned, type of work, etc): _____

Other important family information: _____

Assessment: (should include the following: mental status, risk assessment, testing, basic needs assessment, projective drawings, play therapy, observation of parent-child interactions)

A mental status examination and risk assessment must be conducted and several options are included on the Family Drive (G:\CARE Clinic\Forms\Mental Status Exams). They include the attached mini mental status exam, the Folstein, MoCA, SLUMS, or the Mental Status Examination. Please note that most mental status exams are not written for children and should be adjusted to match their age.

Treatment Priority Rating Scale: Should be completed in Apricot at intake and every 3 months.

Mini-MSE

Orientation

Name:

Date:
(*for young children*: Age:____ Grade:____)

Place: What city are you in?

Purpose: Why are you here today?

Immediate Recall

Remember 5 items (***for young children,*** *choose 2 or 3*):

Apple Car Tree Chair Ball

General Knowledge

Name any 5 Presidents:
(***for young children***: 3-5 colors, Disney princesses, superheroes, etc.)

Name any 5 US cities:

(Gross Motor) Point to your nose. Point to your foot. Point to your ear.

Mental Processes

(Computation) Serial 7's: Start w/ 100 and count backwards in increments of 7
(***for young children,*** count to 10):

100, 93, 86, 79, 72, 65, …

(Mental manipulation) Spell the word WORLD Spell it backwards
(***for young children,*** spell CAT, DOG)

Abstract Reasoning

What does the following phrase mean?

"Don't cry over spilled milk."

"You can't judge a book by its cover."

Delayed Recall

What were those 5 items?

Apple Car Tree Chair Ball

Risk Assessment

☐ Self harm gestures/ideation
☐ Homicidal gestures/ideation
☐ Aggression to others/property
☐ Delusions/hallucinations
☐ Other:

☐ Suicidal gestures/ideation
☐ Risky sexual behaviors
☐ Current substance use/abuse
☐ Other high-risk behaviors (i.e., dangerous/thrill-seeking)

Explain: _____

Treatment Priority Rating Scale

Priority ranking (circle one for each symptom):

0 □□Not currently a problem: no treatment currently necessary

1 □□Suspected, requires further investigation

2 □□Problematic, but not an immediate treatment priority: treat at lower intensity

3 □□Problematic, a current treatment priority: treat at higher intensity

4 □□Most problematic, requires immediate attention

Date:	(Intake)	_____	_____	_____
Problem Area	Tx Priority	Tx Priority	Tx Priority	Tx Priority
1. Assessment/Tx planning	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
2. Caretaker support issues	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
3. Safety (environmental)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
4. Suicidality	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
5. Self-mutilation	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
6. Substance abuse	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
7. Sexual concerns/dysfunctional bx	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
8. Anxiety	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
9. Depression	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
10. Anger/aggression	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
11. Low self-esteem	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
12. Posttraumatic stress	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
13. Dissociation	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
14. Somatization	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
15. Affect regulation/acting out	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
16. Attachment insecurity/relational	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
17. Social skills deficits	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
18. Identity issues	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
19. Grief	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
20. School adjustment	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
21. Difficulty engaging in tx	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
22. Advocacy	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
23. Other:_____	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
24. Other_____	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Total score:	_____	_____	_____	_____

Source: From Appendix III of J. Briere and C. Lanktree (2011), *Treating Complex Trauma in Adolescents and Young Adults.* Thousand Oaks, CA: SAGE Publications.159

UNIVERSITY of MARYLAND
CHILDREN'S HOSPITAL

CENTER FOR FAMILIES –THE CARE CLINIC
Initial Treatment Plan

Client Name:		**Date of Birth**	
Date Treatment Began:		**Date of Treatment Plan:**	

Diagnosis (DSM 5):

Treatment Goals/Progress:

	Long-Term Goals w/ Short-Term Objectives
1.	
	a.
	b.
	c.
2.	
	a.
	b.
	c.
3.	
	a.
	b.
	c.
4.	
	a.
	b.
	c.

Care Clinic Treatment team members responsible (list services provided):

☐	Individual Therapist:		☐	Family Therapist:	
☐	Supervisor:		☐	Psychologist:	
☐	Psychiatrist:		☐	Other:	

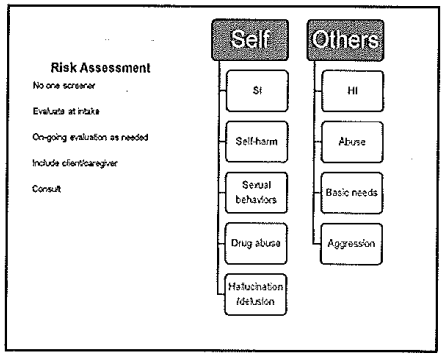
By signing below, I agree to the diagnosis and treatment plan described above. I understand that the treatment plan is subject to review every 3 months, and treatment goals and objectives can be changed in cooperation with the clinical staff involved.

Client	Date	Clinician	Date
Parent/Guardian	Date	Supervisor	Date

Safety Component

Objectives

- Risk assessments
- Child maltreatment
- Policies and procedures on risk issues
- Safety planning
- Interventions
- Confidentiality



Confidentiality

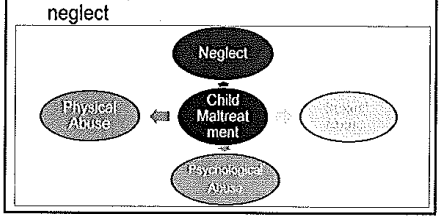
- Must explain the limits
  - Abuse of vulnerable person
  - Imminent danger to self or other
- Children
- Adults

Interventions

- Safety plans
- Refer
  - Crisis response
  - Hospital
  - 911/ER
- Report
  - Duty to warn
  - Abuse/neglect

What is reportable?

- **CODE OF MARYLAND REGULATIONS (COMAR)** defines child abuse and child neglect



Physical Abuse

- Physical injury *not necessarily visible* of a child under circumstances that indicate that a child's health or welfare is harmed or at substantial risk of being harmed.

(COMAR)

Sexual Abuse

- An act or acts involving sexual molestation or exploitation whether physical injuries are sustained or not.

(COMAR)

Neglect

- The failure to give proper care and attention to a child including the leaving a child unattended where the child's health or welfare is harmed or a child is placed in substantial risk of harm.

(COMAR)

Mental Injury

- Identifiable and substantial impairment of a child's mental or psychological ability to function.

(COMAR)

Reaching a Threshold for Reporting Abuse

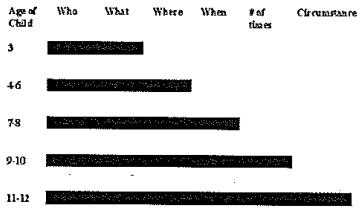
- If you *suspect*, make the call
- Disadvantage groups

How to respond to suspicion?

- Consult
- Gather information
- Determine if tell the child or adult that you will be making a CPS report
- Make report

Guidelines for Age-Appropriate Interview Questions

Adapted from: Walker-Perry & Saywitz



How do I make a report?

- Complete Form 180
  - http://www.dhr.maryland.gov/cps/pdf/form180.pdf
- Call the county where the alleged maltreatment occurred
  - Contact info. for all Maryland CPS departments http://www.dhr.maryland.gov/cps/address.php
- Fax the 180 form to CPS then mail hardcopy
- Email Roger Ward, Chief Accountability Officer
- Document in client's chart

Possible Responses

Screened Out

About 40% of reports are deemed insufficient to investigate or respond to

Investigative Response

Interviews and assessment of safety & service needs

Alternative Response

Low –risk situations, work with families to provide services

Resources

- Department of Human Resources http://dhr.maryland.gov/cps/mandated.php
- Child Protection Team: 410-706-5176

Goals versus Objectives

Goals are the overarching plan while the objectives spell out how to get to thr goal. Below are some samples definitions and comparisons of goals versus objectives.

Forbes

G'SOT: **G**oals, **S**trategies, **O**bjectives and **T**actics (the G'SOT)

- A **goal** is a broad primary outcome.
- A **strategy** is the approach you take to achieve a goal.
- An **objective** is a measurable step you take to achieve a strategy.
- A **tactic** is a tool you use in pursuing an objective associated with a strategy.

https://www.forbes.com/sites/mikalbelicove/2013/09/27/understanding-goals-strategies-objectives-and-tactics-in-the-age-of-social/#6a82f1364c79

Diffen

The words **goal** and **objective** are often confused with each other. They both describe things that a person may want to achieve or attain but in relative terms may mean different things. Both are desired outcomes of work done by a person but what sets them apart is the time frame, attributes they're set for and the effect they inflict.

Comparison chart

Goal versus Objective comparison chart

	Goal	**Objective**
Meaning	The purpose toward which an endeavor is directed.	Something that one's efforts or actions are intended to attain or accomplish; purpose; target.
Example	I want to achieve success in the field of genetic research and do what no one has ever done.	I want to complete this thesis on genetic research by the end of this month.
Action	Generic action, or better still, an outcome towards which we strive.	Specific action - the objective supports attainment of the associated goal.
Measure	Goals may not be strictly measurable or tangible.	Must be measurable and tangible.
Time frame	Longer term	Mid to short term

http://www.diffen.com/difference/Goal_vs_Objective

Good Therapy.org

- **Treatment Goals**: Goals are the building blocks of the treatment plan. They are designed to be specific, realistic, and tailored to the needs of the person in therapy. The language should also meet the person on their level. Goals are usually measurable—rating scales, target percentages, and behavioral tracking can be incorporated into the goal language to ensure that it is measurable.
- **Objectives**: Goals are often broken down into objectives in order to support the person in therapy through the process of taking small, achievable steps toward the completion of the larger goal.

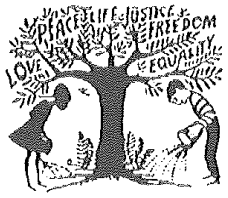
http://www.goodtherapy.org/blog/psychpedia/treatment-plan

Advocacy & Systems Intervention

Care Clinic Intern Training Program

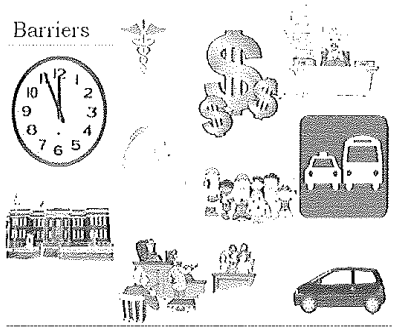
Goals of Advocacy

- Help clients access our services
- Help clients access other needed services
- Advocate for client needs



Accessing our services

Barriers

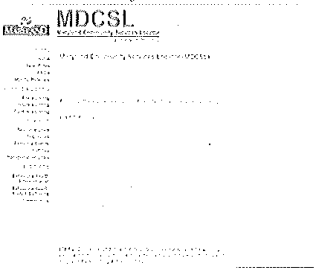


Interventions

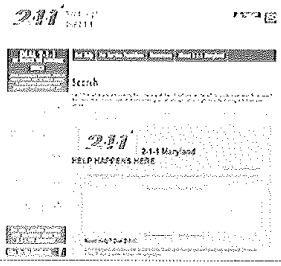
How to find resources

Linking clients to other resources

Maryland Community Services Locator



United Way



Advocate in other systems

Systems Interventions

Systems

- School
- Work
- DSS/CPS
- Court
- Others?

*Therapy Environment

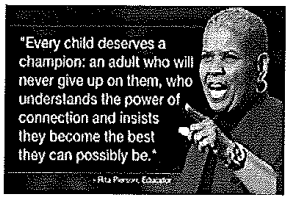
Relationship and Physical Environment

*safe
*respectful
*culturally responsive
*consistent
*reliable
*Supportive
*encourage growth
*nonintrusive
*empathetic
*attuned
*honest
*respectful
*protect confidentiality
*understanding

*Positive Therapeutic Relationship

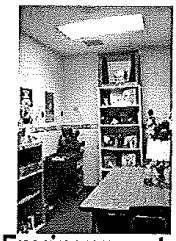
*Every Kids Needs a Champion

Rita Pierson



https://www.youtube.com/watch?v=SFnMTHhKdkw

*Lighting
*Clutter
*Aesthetics
*Scent
*Sounds
*Movement



*Learning Environment

*Therapy Environment should be:

*safe,
*welcoming,
*culturally responsive
*child-friendly
*clean and orderly
*predictable
*appropriate therapy materials
*free from distraction

Distress Reduction & Affect Regulation

Care Clinic Intern Training Program

Comparison

Distress Reduction
- Acute state
- Relaxation techniques
- Grounding

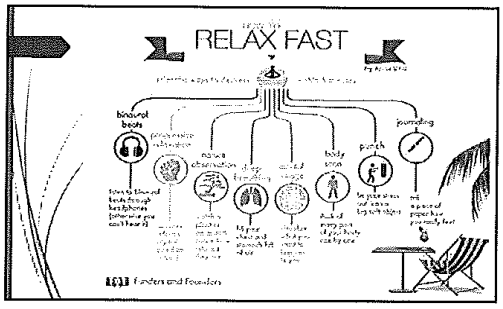
Affect Regulation
- Chronic
- Thoughts and Feelings work
- Positive thinking
- Trigger management

Distress Reduction

Dissociation, Abreaction, & other acute states

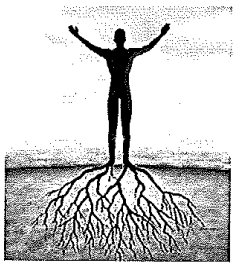
Relaxation techniques

- Diaphragmatic breathing
- Visual imagery
- Muscle relaxation
- Meditation/Prayer
- Mindfulness
- Exercise
- Stretching



Grounding

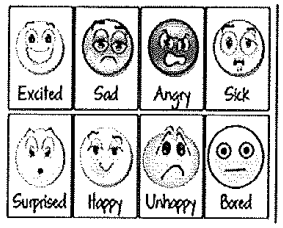
- In the moment
- Attend to the senses



Affect Regulation

Chronic States

Feelings Expression



Positive Thinking

p○ itive thoughts
generate
p○ itive feelings
and attract
p○ itive life
experiences

Trigger Management

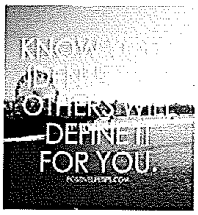
- Information on triggers
- Identifying their triggers
- Plan how to respond to triggers

Where to find resources

- Therapy rooms and closet/observation room
- ITCT manuals
- Resource drawer in Rm 113
- Resource folder on G drive/Care Clinic
- Resource manual
- Pinterest
- Google

Facilitating Positive Identity & Relational Processing

Facilitating Positive Identity



Techniques

- Safety
- Self-exploration
- Support
- Affirmation
- validation
- Identity development activities
- Positive experiences
- Role-play social skills
- Open-ended questions

Identity Development Activities

Anagram

- Write the letters of your name down a sheet of paper.
- For each letter, write a word or phrase that describes you.
- What was the process like?

Self-portrait

- Draw a picture of yourself.
- Option – add images, words, or symbols for your interests, traits, etc.
- Collage – images for your interests, traits etc.
- Which option were you most comfortable with?

Relational Processing

Signs of Relational Issues

- Fear of people/relationships
- Inability to trust
- Over-attached to people
- Attach too quickly
- Emotional response out of proportion to context
- Problems interacting with others

How to respond

- Differently than their perpetrator
- Acceptance
- Patience
- Boundaries
- Kindness
- Respect
- Process the interactions
- Allow time to build trust

Your words are not enough. You must show it.

Trauma Narrative Outline

Adapted from Liana Lowenstein's "My Story"

The story about the trauma can be drawn, written, acted out (i.e. puppet show or with figurines), done as a cartoon, collage, poem, letter, timeline, or whatever means is best for the client. Below are some the key areas to include in the story and things can be added or taken away as needed. The outline is divided into 8 "chapters."

1. About Me

Demographic information: name, age, where you live, who you live with, school and grade, interests, hobbies, physical appearance, race/ethnicity, career goals, friends, strengths, what's important to you, etc.

2. Before the Trauma

What life was like before the trauma with you, your family, at school, with your friends, etc. If you knew the perpetrator/person who mistreated your or your loved one what was your relationship with them like. How did you think and feel about your life before the trauma. How did you view the world and most people (i.e. is it a safe place and most people are nice?).

3. About the Trauma

Include as much detail as you can about what happened such as who (who was mistreated and who the perpetrator was), what, where, when (day, time, season, time of day, number of times, etc), and how. Write about what you were doing, saying, thinking, and feelings (physically and emotionally) during the trauma. Rate your thoughts and feelings. Is there anything you particularly noticed during the trauma (i.e. sights, sound, smell, sensation, taste)?

4. The Worst Part

What was the worst part of the situation and what are your thoughts, feelings, and body sensations now as you think about it.

5. Disclosure

How was the trauma discovered? What happened when people found out? If you had kept it a secret, what stopped you from talking about it? Who did you have to tell and what was it like? How did they respond? Who do you think believes and supports you? Who doesn't? Have you had to testify and what was it like?

6. Since the Trauma

How's life been for you and your family since the trauma? What are your symptoms, triggers, and coping skills? Include how you and your friends and family feel and think, how everyone has been dealing with the trauma, and what things have changed.

7. What I Learned

How are you different now from when therapy began? What have you learned about taking care of yourself and dealing with the trauma? What advice would you give to other children who have been mistreated and/or through a traumatic event? What you like to say to the perpetrator now? Have your thoughts and feelings about the trauma changed and if so, how? Is there anything that you would like to do to make yourself and/or others feel better?

8. My future

What do you think or hope your life will be like in the future? What are your goals?

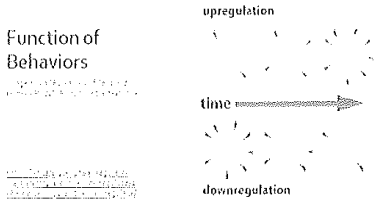
BEHAVIORAL SELF-CONTROL SKILLS

TEST Component

Acting out behaviors

- Substance abuse
- Aggression
- Self-harm
- Disruption
- Severe/reactive behaviors
- Rule/law breaking
- Tantrums

Function of Behaviors

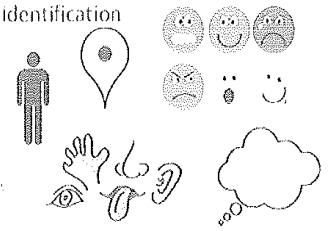


Trigger Responses

- Out of proportion
- Trauma-related/emotional
- Changes in awareness

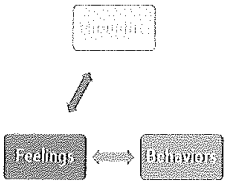
Trigger Identification

- Person
- Place
- Thing
- Situation
- Thought
- Feelings
- Experience
- Sensory input



Emotional Regulation Skills

The Cognitive Triangle



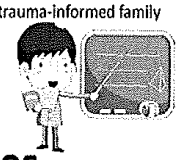
Caregiver Involvement

- Psychoeducation
- Help identify triggers and plan
- Remind child/adolescent to use plan

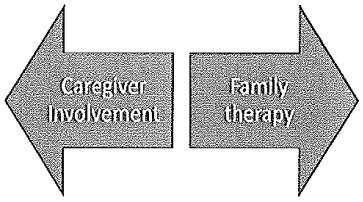
April Rectanus, MA, LCPC
Care Clinic: UMB

Family Therapy with Trauma Survivors

» To understand the impact of trauma on individuals and families
» To determine the goals of family therapy for trauma survivors
» To be familiar with trauma-informed family therapies



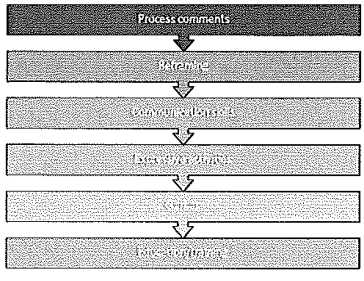
Objectives



Caregiver Involvement
» Check-ins
» Coping skills
» Psychoeducation Safety planning
» Trauma narrative

Family therapy
» Communication
» Relationship building
» Parenting/behavior management
» Expressing thoughts and feelings
» Trauma narrative
» Reunification

Goals



Interventions

» PCIT – Eyeberg
» CPP – Leiberman & VanHorn
» Triple P – Positive Parenting Program
» Play in Family Therapy – Gil
» Structural
» Home vs clinic-based
» Manualized vs open format

Therapies

PCIT

- Children ages 2-7 and their caregivers
- Children with problems related to internalizing, externalizing, pre-conduct disordered, or abuse- reactive behaviors
- Use direct coaching
- Focus on both relationship building and behavior management

PCIT: Interventions

- Intake Assessment
- Teach & coach skills
- Behavioral play therapy
- Discipline skills

CPP

- Birth-5y.o.
- Relationship-based
- Address negative effects that arise when caregiver unable to protect child
- Effective for high-risk toddlers & preschoolers
- Benefits:
  - Symptom reduction for child and mother
  - Improve mother-child relationship
  - More secure child attachment
  - Child's cognitive functioning improves

CPP: Interventions

- Core role: Translating for the parent and child
- Supporting Developmental Momentum – Playing, Putting Feelings Into Word, & Protective Physical Contact
- Unstructured Reflective Developmental Guidance: Principles of Early Child Development
- Modeling Appropriate Protective Behavior
- Insight-Oriented Interpretation
- Addressing Traumatic Reminders: Trauma Narratives
- Retrieving Benevolent Memories
- Emotional Support
- Attention to Reality: Crisis Intervention, Case management, Concrete Assistance

Triple P

- Safe and Engaging Environment
- Positive Learning Environment
- Assertive Discipline
- Realistic Expectations
- Parental Self-Care

Other issues

- Who to include in sessions
- Work with the perpetrator
- DSS involvement
- Legal issues
- Attendance
- Case management
- Foster parents

Questions

References

» Hembree-Kigin T.L. & McNeil, C.B. (2010). *Parent-Child Interation Therapy, 2nd Ed.* Plenum Press, New York

» Lieberman, A.F. & VanHorn, P. (2008). *Psychotherapy with Infants and Young Children.* Guilford Press, New York.

Vicarious Trauma and Posttraumatic Growth

Identification and Interventions

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Personal Inventory

You will only be asked to share what you feel comfortable with.

Learning Objectives

- Participants will be able to:
  - Define vicarious trauma and post-traumatic growth
  - Identify their own symptoms of vicarious trauma and growth
  - Create a self-care plan to reduce symptoms of VT

What is Vicarious Trauma?

- Other names often used in place of "vicarious trauma"
  - Traumatic Countertransference
  - Secondary Traumatization
  - Posttraumatic Stress Disorder
- Similar, but not quite the same as:
  - Burnout
  - Compassion Fatigue

Working Title of Vicarious Trauma

- A negative transformation due to working with and caring about trauma victims.
- Includes elements of PTSD, along with changes in:
  - Identity
  - Worldview
  - Self-Soothing capacities
  - Sense of safety
  - Capacity to trust others and maintain intimacy

Risk factor for VT

- Negative coping skills
- Stress
- Being female
- Own trauma history (research is mixed)

PTSD Diagnostic Criteria

- Re-experiencing of trauma
  - Recurrent dreams
  - Acting or feeling as if events were recurring
  - Flashbacks or intrusive memories
- Avoidance of trauma-related stimuli
  - Efforts to avoid thoughts, feelings, etc.
  - Inability to recall important aspects of the trauma
  - Markedly diminished interest in certain activities
  - Feelings of detachment or estrangement
- Persistent symptoms of arousal
  - Irritability or outbursts of anger
  - Difficulty concentrating
  - Difficulty falling or staying asleep
  - Exaggerated startle response
- Negative cognitions/distortions
  - Undue sense of guilt/blame
  - Sense of shame connected to events
  - Distorted worldview
  - Depressive symptoms

How might these symptoms manifest in healthcare providers?

Self-awareness Worksheet

Circle the items that you experience as a result of doing this work.

What professions are vulnerable to vicarious trauma?

- Mental health clinicians working with victims
- Law enforcement
- Child protective workers
- Firefighters
- Emergency care workers
- Residents
- DSS caseworkers

What are some examples of impactful events, situations, or triggers for you?

What is Vicarious Posttraumatic Growth (VPTG)

- Positive effects due to working with trauma victims.
- Psychological change that mirrors the positive growth in trauma survivors
- Examples?

What determines VT or VPTG

- Organizational factors
- Personal strategies
- Individual characteristics
- Social support

How to prevent/treat VT and increase VPTG:

- Increase organizational awareness and support
- Help clinicians develop self-awareness towards symptoms of vicarious trauma
- Opportunities to witness client/patient PTG
- Develop prevention plans
  - Professional plan
  - Personal plan

Develop a Self-Care Plan

- Physical/Medical
- Psychological
- Emotional
- Spiritual
- Work Place/Professional
- Balance

Self-Care Plan

Rate how often you do each of the following and then create your own self-care plan.

Questions?

References

- Cohen, K. & Collens, P. (2012). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma Therapist, Research, Practice, and Policy*, 5(6), 570-580.
- Saakvitne, K.W., Gamble, S., Pearlman, L.A., & Lev, B.T. (2000). *Risking Connection; A Training Curriculum for Working with Survivors of Childhood Abuse.* Baltimore, MD: Sidran Foundation and Press

Bio-sketch

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April Rectanus has a Doctorate of Education with a specialization in Counseling from Johns Hopkins University. She also has her master's degree in clinical psychology. Ms. Rectanus is a Licensed Clinical Professional Counselor (LCPC) and an approved supervisor through Maryland's Board of Professional Counselors and Therapists. Since entering the field in 2000, Ms. Rectanus has provided individual group, and family therapy for children and adults as well as training and supervision for therapists. Her expertise is in trauma and managing emotional and behavioral issues (i.e. anxiety, depression, ADHD, disruptive behaviors). Currently, Ms. Rectanus is the director of the Care Clinic at the University of Maryland Baltimore. The Care Clinic specializes in treating victims of child maltreatment and providing supervision and training to other professional in trauma treatment. Ms. Rectanus created and coordinates a training program for interns/externs on evidenced-based trauma treatment and is currently piloting a training curriculum for treating complex trauma and trauma-focused counselor competency assessment measure.